The Encyclopedia

of MENTAL

HEALTH

Albert Deutsch, EDITOR IN CHIEF

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VOLUME II

Printed in the U.S.A.

CONSTITUTIONAL VARIATION AND MENTAL HEALTH

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What is meant by constitution?

The constitution of a thing, whether animate or inanimate, is its structural makeup—the nature and the arrangement or pattern of the stuff of which it is composed. Literally, the constitution of anything is the characteristic manner in which it is put together. Practically, and almost universally when applied to living creatures, the term constitution means structural individuality.

No two human beings are exactly alike. People are constituted differently, and so of course they behave differently, both normally and when in trouble or under stress. Basic to all branches of medical, anthropological, biological, and psychological science as it is applied to human beings is the problem of recognizing and delineating the individual peculiarities of the particular person who is under study. The sum of all the identifying characteristics that set this person apart and give him his continuing or permanent individuality may be regarded as his constitutional equipment.

Your constitution is, of course, derived from your genetic heredity. The whole pattern of your constitution has grown into its present being because your genes, which were contributed by your parents, carried within their nucleoprotein structures certain built-in instructions. These instructions at first had to do principally with the processes of cellular modification and division, or growth, in response to stimuli provided by or resulting from the environment. Later, as you began to take on form and substance—as your constitution began to develop and to become manifest—cellular modification progressed rapidly and although all cells still carried complete sets of the original instructions, the various colonies of the now differentiated or specialized cells were able to respond only selectively and limitedly to the instructions they

carried. This was a penalty of specialization, but the resulting division of labor enormously enhanced the biological efficiency and the behavioral potential of the developing organism.

Specialization was superimposed upon specialization. A somatic (body) frame took shape, with its distribution of bone, muscle, and connective tissue. A digestive system (with its glandular appendages) developed together with a circulatory system to carry nutrition and maintenance to all parts of the body. And there developed an integumental system, the skin, with its many specialized appendages, including the brain and nervous system together with its complement of sense organs; and organs for sexual reproduction. (See *Heredity and Mental Health*)

You may have a somatic frame that is very small, very large, or somewhere between these extremes. Within this somatic house (which is where you live) the bones and muscles and their connective ligaments may all be harmoniously developed and in fine balance. Or you may be meeting your world with poorly integrated somatic structure—fine or crude skeletal architecture together with either fine or crude muscular elaboration, complicated (or helped) by either crude or fine connective tissue development. These are rather basic and very easily assessed constitutional characteristics. They make you an efficient athlete or, at the other extreme, a stumbling caricature of somatic ineptitude.

The digestive system is primarily a long muscular tube with digestive glands distributed throughout almost its whole extent, and with several large, specialized glandular structures intimately associated. Taken as a whole, this is the central core of a living animal—the very seat of life, and the vital tie with the earth. How you are constituted in the way of digestive equipment—whether overendowed or underendowed and whether all parts of the system are harmoniously developed and well integrated and efficient—this visceral constitutional characteristic may be the most important determiner of all in laying the foundations of what psychologists call personality and psychiatrists call mental health.

If the soma is the house you live in, the visceral organs are perhaps the essential you. The nervous system and brain provide an internal telephone service and also a varied set of periscope devices by means of which you look outward from your internal salt water world to see (and hear, feel, taste, and smell) the immediately impinging universe. The whole structure is your constitution, and it is worth getting acquainted with for it offers perhaps the main direct road to self-understanding. Moreover, it is unique. There never was and never will be another exactly like it.

What is the somatotype?

Somatotyping has been developed as a beginning, or first approach, to the basic study of human variation on an objective basis. The theory and methodology of this approach to the problem are presented in the first four volumes of a series on human constitution:

Varieties of Human Physique, by W. H. Sheldon, S. S. Stevens, and W. B. Tucker

Varieties of Temperament, by W. H. Sheldon and S. S. Stevens

Varieties of Delinquent Youth, by W. H. Sheldon, E. M. Hartl, and E. McDermott

Atlas of Men, by W. H. Sheldon, C. W. Dupertuis, and E. McDermott

The somatotype is simply a formula expressing the relative strength of three primary components which, following the results of factor analysis and of empirical experiment, appear to be basic in determining an individual's permanent pattern of body build. The three components are quantified on a seven-point scale and are expressed as a series of three numerals: the first numeral designating "endomorphy," the second, "mesomorphy," and the third, "ectomorphy." Thus the somatotype 7 4 1 reflects an extreme maximum for endomorphic endowment, an extreme minimum for ectomorphy, and a position near the midpoint of the scale for mesomorphy.

Endomorphy and mesomorphy describe compactness of the body, but two quite different kinds of compactness. Endomorphy means relative predominance of the digestive system in the bodily economy, hence relatively great development of the digestive viscera, and of the abdominal segment housing them. In embryonic life the *endoderm* (the inner embryonic layer) grows principally into what becomes the functional element in the digestive or vegetative system and its appendages. Endomorphs, therefore, are digestive athletes of a sort. They are champion processors of food, easily producing surplus fat and storing it throughout the body. Thus they tend to take on roundness of form— to become spherically compact. The abdominal segment of the body prevails.

The embryonic *mesoderm* gives rise to the somatic frame—the bone, muscle, and connective tissue—and in fact to the supportive framework of all the component elements of the body. Mesomorphs are compact because they are heavily packed with hard substance, chiefly bone and muscle. The thoracic segment (engine room) tends to prevail markedly

over the abdominal segment (boiler room), and of course the arms and legs are more strongly developed. Mesomorphy means athletic potential in the conventional sense, muscular power, and ruggedness. As mature endomorphs tend toward spherical form, mesomorphs suggest squareness, rectangularity, or cuboid structure, when they mature. In extreme mesomorphy the thoracic segment (chest region) prevails dramatically over the abdominal region.

Ectomorphy designates stretched-outness—an opposite to both kinds of compactness. In endomorphy and mesomorphy, mass predominates conspicuously over surface. In the third component, ectomorphy, the biological investment is toward extension of surface—at the expense of both kinds of mass, of course. The embryonic *ectoderm* gives rise to the skin and its appendages, which include the nervous system and the active elements in the sense organs. Therefore, ectomorphs are skinny in the literal sense. Relatively, they have more skin than viscera or bone and muscle. They have to invest in more skin because of the relatively greater amount of surface in proportion to the amount of mass. An ectomorph has biologically stretched out his neck—and his limbs and trunk as well. An ectomorphic creature (of any kind) seems to be one who has surrendered the relative security and the biological advantages of compact massiveness in favor of the pursuit, presumably, of other kinds of advantage that may perhaps accrue from an adventurous extension into what (for the growing organism) is unknown space. Under normal conditions the ectomorphic way of life would seem to be a dangerous way. Perhaps it is. That may be a reason why ectomorphs, when they break mentally, tend to break severely, with poor prognosis.

How objectively can the somatotype be determined?

Insofar as endomorphy is manifested by abdominally dominated compactness, mesomorphy by chest-dominated compactness, and ectomorphy by stretched-outness, it would seem reasonable to expect that a very few fairly simple parameters (constants) might be found that: (a) would reflect these three tendencies, and (b) might be sufficiently uncorrelated and independent of each other to bracket somatotypes within a three-dimensional system.

Search for parameters of this nature went on steadily among students of the problem for quite a number of years. Many measurements, indices, and ratios were tried. Most were discarded. However, it has been found that the somatotype can be pinpointed with statistical re-

liability (and validity) when the following three parameters are available:

1) Maximal height, or stature.

2) Shape index, or trunk index, which is an index derived from dividing the planimetrically measured photographic area of the thoracic (upper) trunk by the similarly measured area of the abdominal (lower) trunk. This is done by dividing the trunk (on a photograph) at the anatomical waistline—a step that any closely observant person can easily be instructed to take accurately. With a planimeter (an instrument for measuring the area of a plane figure) the respective areas are then measured just as areas on a map are measured.

3) Height divided by the cube root of weight, or ponderal index. The practical difficulty with the ponderal index is that it is not useful except where the heaviest weight in the person's history—and also his height at that time—is known. When these data are not available it is necessary to find a substitute for this third parameter in order to achieve perfectly objective somatotyping.

The best substitute available is the distal index. This is the mean of a number of transverse measurements (forearm and wrist, lower leg and ankle), each expressed as a ratio to stature.

The distal index varies only very slightly with nutritional (weight) change or aging, since it is based largely on skeletal thicknesses. Trunk index was found to vary almost not at all in a series of men photographed both in their late teens (as college freshmen) and forty years later, although some of them had changed very radically in weight. Similar results were found in pictures of a series of young men who were photographed both before and after a "starvation experiment," although some of these subjects had lost nearly half their weight; and were also found in pictures of a series of subjects who have been followed in a longitudinal study and photographed every year from age two or three until full maturity was reached. Shape index turned out to be a constant in all these studies.

Maximal height, once reached, is of course also a constant, by definition. The one weakness with this parameter is that, in the case of growing children, it is necessary (in order to set up objective somatotyping) to use a height correction, or height prediction, based on one of the available prediction charts. However, at least one of these prediction charts (Nancy Bayley chart) has been proved remarkably accurate.

With three parameters, then, somatotyping can be accomplished with complete objectivity by using routine, and now widely available, com-

puter equipment. The same step can be taken much more easily for a small series, or more cumbersomely for a very large series, with published tables that are now available to people working in the field.

Does the somatotype give us the whole picture of constitutional variation?

By no means; it supplies only an operational beginning. Probably more important than the basic somatotype, so far as the direct determination of personality is concerned, are the measurable secondary components of the somatotype, particularly *dysplasia, aplasia, andric* endowment, *gynic* endowment, and the *andric-gynic* ratio (a/g ratio), and beyond this, of course, the whole array of variables that can be measured microscopically, clinically, or chemically. In fact, anything that can be learned about an individual by biologists or psychologists or anthropologists becomes an important piece to fit into the picture once the basic frame of reference (the somatotype) has been determined. Conceivably, scientific analysis of personality then becomes a true possibility.

Dysplasia is a measure of the extent to which an individual presents different somatotypic proportions in different areas of the body. Analysis of a person's dysplasias offers a good beginning for almost any kind of psychological or psychiatric analysis, not excluding psychoanalysis.

Aplasia is simply defective or incomplete development. Extreme examples are harelip and spinal deformities. Several medical entities present specific patterns of aplasia. Marfan's syndrome, for example, involves developmental failure of (mesodermal) connective tissue elements in certain bodily regions. Aplasias of the nose and of other facial features are common.

The andric and gynic components (the expressions of masculine and feminine characteristics throughout the body) can be estimated quantitatively with great accuracy. A man or woman can be heavily endowed in both andric and gynic, underendowed in both, up in one but down in the other, or balanced at the mean for the sex in both. The a/g ratio is undoubtedly one of the most important constitutional factors in determining personality.

Is there a relationship between physique and temperament, e.g., the fat jovial man and the skinny nervous man? How can temperament be classified?

The term "temperament" comes from the Greek verb meaning to mix. Literally, an individual's temperament is the mixture or blend

that he represents. The question is—blend of what? What are the most meaningful, or most basic or elemental components entering into the innumerable mixtures that express themselves as human temperaments? When this question can be answered in a completely satisfactory manner, when we are fairly sure as to the nature and identity of the most basic elements of temperament, it will be possible to look upon the psychology of personality study as an operational science. (See *Personality; Character Structure*)

The prevailing view of students of human constitution is that personality develops from, and is an expression of, the original temperament pattern (as the latter is thrown into contact and interaction with its environment) in very much the same way that temperament, in a developing organism, expresses and elaborates the original constitutional endowment, which is measured by the somatotype, the andric and gynic endowments, the dysplasias, and so on.

At the beginning of the work in this field, a search for the primary components of temperament appeared to be the most important assignment to be undertaken. This was the principal task long before the problem of somatotyping was taken up.

A series of cluster analysis studies of all the alleged traits of temperament that could be collected suggested the possibility that the best operational beginning for temperament analysis might rest on a matrix of three primary components—rather than the larger number that most students of personality then tended to subsume. The three primary components of temperament were presented as *viscerotonia, somatotonia,* and *cerebrotonia* in *Varieties of Temperament.*

Viscerotonia is characterized by traits arising from or associated with a predominant luxuriance of the digestive endowment; somatotonia is associated with somatic predominance; and cerebrotonia is associated with (1) biological extroversion or overexposure, (2) consequent inhibition of both visceral and somatic functions, (3) substitution of symbolic and abstractive processes (which in pathology may become ends in themselves and can lead to what we call schizophrenia, and so on).

That viscerotonia must be related to endomorphy, somatotonia to mesomorphy, and cerebrotonia to ectomorphy, became obvious enough after somatotyping was made available. But just how close the relationship is depends on definition and on how competently the analysis of temperament is carried out.

Using the term "temperament" in its literal meaning—mixture (of components)—the somatotype is, of course, only one indicator of tem-

perament, an indicator at the relatively fixed level of permanent morphology (the form and structure of plants or animals). Measures of correlation between somatotype and temperament then become almost meaningless, for they are simply dealing with the same component at perhaps only slightly different levels of its expression.

Are endomorphs jovial? They are viscerotonic, which means they are relaxed, biologically introverted (therefore socially extroverted or outgoing), and oriented to good eating and good company. And since they are neither fast in reaction nor loaded with muscular threat, they tend to be fairly safe, pleasant company. The coach of the Chicago Bears professional football team is an excellent constitutional psychologist. Almost all of his players are somatotonic mesomorphs. Professional basketball, however, is something different. Basketball players need ectomorphic tallness in addition to mesomorphic speed and power, and also all the endomorphic relaxation they can get. Basketball teams are made up of extremely high-total somatotypes. In basketball players the sum of the three components tends to reach 13, 14, and even 15. In schizophrenia, by contrast, many 9's, 8's and even 7's are found.

Is there an association between constitutional variation and mental or emotional disorder?

During the past three or four decades observers of the psychiatric scene have noted a weakening of the earlier classificational typologies which were applied to mental disorder. Psychiatric terminology has changed radically within a generation. It is no longer so certain that there are such "entities" as mental diseases causing the characteristic patterns of behavior disorder encountered among patients. There has been a growing feeling that a new approach to psychiatric description and explanation is needed. In *Varieties of Delinquent Youth* a proposal is outlined for an operational beginning in this direction.

In this book it was reported that at Elgin State Hospital, Illinois, in the mid-1940's, 155 psychotic men were studied. Following the pattern of Phyllis Wittman's Elgin Checklist of Fundamental Psychotic Behavior Reactions (in her report in *The Journal of Nervous and Mental Disease,* Vol. 108, No. 6, Dec. 1948) members of the psychiatric staff made quantitative ratings as to how much of each of three traditional components of psychotic reaction each of the 155 patients manifested.

1) How much affective-conative (pertaining to conscious striving) exaggeration (manic, depressive, or manic-depressive);

2) How much paranoid projection (sustained resistive hostility);

3) How much schizoid regression (withdrawal toward helplessness and toward bizarre affect and ideation).

These three putative primary components came to be called simply the first, second, and third psychiatric components: the first, *manic* or *Dionysian;* the second, *paranoid;* the third, *hebephrenic.*

Twelve of the 155 patients received diagnostic ratings as expressing predominantly the first psychiatric component, or primarily manic. They were massive men, reflecting almost a polar antithesis to ecto-morphy.

Twenty-seven of the 155 received diagnostic ratings classing them as predominantly paranoid—the second psychiatric component. The soma-totypes of these 27 are in the area farthest from polar endomorphy.

Eighty-five of the 155 were rated as expressing predominantly the third psychiatric component, or primarily hebephrenic. The somato-types of these patients show a fairly marked tendency to cluster toward the ectomorphic pole, with a secondary but much less pronounced drift toward endomorphy.

Finally, 31 of the 155 received ratings leaving them rather evenly balanced with respect to the three primary psychiatric components. Under varying conditions and at different times, these men showed manic characteristics, and also paranoid and hebephrenic reaction patterns. In most instances the diagnosis was catatonic schizophrenia. Their somatotype characteristic seems to be simply that they occupied positions in or near the central area of the somatotype distribution.

These findings are in close agreement with the central theme of Ernst Kretschmer's monumental book, which in the English translation is titled, *Physique and Character.* Kretschmer found that patients of manic or Dionysian temperament were somatotypically pyknic (mas-sive, i.e., opposite to ectomorphy); patients of schizoid temperament, leptosomic (delicate-bodied, ectomorphic); and those of predominantly paranoid temperament, he found lacking in the endomorphic compo-nent. A large number of the rest of Kretschmer's patients were "mid-range"—falling near the central area of the distribution with respect to manifest temperament and also with respect to somatotype.

Kretschmer's central thesis was essentially this: physique and tem-perament are closely related, like different levels of complexity of one thing; therefore, the most basic components in physique must also be the basic components in temperament; a really adequate description of the basic components of physical variation should therefore constitute

the best beginning toward analysis of temperament and consequently toward any form of psychiatric analysis.

This does not seem a very radical idea. Sigmund Freud, during his later life, stated more than once that if a satisfactory method of somatotypic analysis were available to him, he would like to use it as the starting point for his approach to psychoanalysis. But in Freud's time, and even in Kretschmer's, nobody had worked out and standardized a somatotyping procedure.

However, in 1949, with the theoretical edifice of somatotyping available, it was only a short step from Kretschmer's splendid descriptions of temperamental variation in the psychiatric disorders to the construction of a diagram for plotting the psychotic reaction patterns against the background of the somatotypes. At levels of psychiatric involvement less severe than the psychotic levels, and sometimes called "psychoneurotic," it can be seen that the same basic components of temperament are arrayed against the somatotype distribution just as they are at the psychotic levels. These same primary temperamental patterns exist also in normal and superior people, and there, too, the temperamental patterns distribute against the somatotypes in the same way.

Therefore, the answer to this question is yes. There *is* an association between constitutional variation and the emotional and mental variations.

Are there constitutional disorders?

There certainly are disorders of development in which the physical structure fails to express or fulfill its genetic potential. Some such disorders result from insufficient or oversufficient nutrition. Others result from conditions prevailing during intrauterine life—the period between conception and birth. All of these are environmental in the sense that they are a consequence of something that happens after the union of the parent cells.

All giantism, and probably almost all dwarfism, results from multiple causation—a genetic factor plus an environmental factor. All known human giants are somatotyped readily by using the basic tables that are now available. In the case of dwarfs there are instances in which the height parameter does not cross the point where the other two parameters meet—the individual is too short. This is a condition encountered only in dwarfs. It is very easily met. A "correction for dwarfism" is

applied to the height parameter—a percentage addition—until the minimum requirements of the most nearly qualifying somatotype are met.

Is it possible for the constitution to change?

The genetic factor in a constitutional endowment cannot be changed after conception has taken place, of course. But the resulting personality, both physical and mental, can be affected by many kinds of environmental influence. If this were not so there would be no purpose in education—or even in eating.

Does constitution determine obesity?

Endomorphy does not necessarily predetermine a person toward obesity. The degree of endomorphy merely determines a person's susceptibility to becoming obese. A person at the extreme upper limit in endomorphy has enormously efficient digestion and a much longer and larger digestive tract than average people. In times of severe food scarcity such an individual becomes important because he is the one most likely to survive the hard times. In times like the present he is often inclined to overlook his digestive efficiency—or perhaps not to learn about himself—and to be obese. It is probably fair to say that in most instances obesity is an unnecessary luxury. (See *Obesity*)

Do constitutional factors influence behavior and personality to a greater degree than environment?

Certainly not, and in a literal sense perhaps not quite so much. Without the constitutional factors there would be no living body and consequently no personality. But without the environment there would be nothing at all. The constitutional factor starts as a genetically transmitted predisposition to react in certain ways within a continuing environment. But the genetic predisposition is itself (presumably) only a pattern of arrangement that has no existence except with respect to the living structures that carry it. These carrying structures—protein structures within the nuclei of cells—are themselves part of the environment, as is the rest of the body. There can be no separation between nature and nurture because the one does not exist apart from the other.

The real problem is not which is the more important factor, but, can understanding and intelligent control be achieved if one factor is ignored? The environmental factor cannot be ignored, of course, for then nutrition would be cut off and death would follow quickly. But a

tendency to ignore the constitutional factor is often present and in many ways is very tempting. The consequences of *that* omission are more remote. For if a human personality fails to live up to its best possibilities and fails to realize its best potential achievement, because of bad constitutional psychology (or none at all) somewhere along the line—or if a human civilization deteriorates and breaks up for the same reason—the suffering is more prolonged and the ultimate consequences may be far more painful.

CORRECTIONAL INSTITUTIONS AND PSYCHIATRY

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What is a "correctional institution"?

It is an institution used for the confinement and rehabilitation of adult offenders convicted of offenses involving sentences of more than one year (felonies). At one time, such offenders were sent to only one type of institution, the prison or penitentiary, which is an institution with high stone walls and an emphasis on security and discipline. In recent years, there has been some shift to goals of rehabilitation and a development of new types of institutions, many with less secure custody arrangements. A typical correctional system today consists of a variety of institutions, ranging from the traditional maximum security prison to the minimum security farm, or to a work or forestry camp.

How many correctional institutions are there and how many people are confined in them? What is the average length of stay?

Each state has its own correctional system, as has the federal government, making a total of 51 correctional systems in the United States. There are about 30 federal institutions and 130 state institutions, with a total inmate population of 217,177 (Dec. 31, 1960). On the basis of previous years' averages, 95 per cent of these prisoners will be released in less than three years.

What are the purposes of confinement in a correctional institution? How successful are most institutions in rehabilitating offenders?

From one point of view, the purpose of confinement is clear: to carry out the sentence of the court. Hidden behind this, however, is a conflict in purpose that has not yet been resolved.

Criminal law is based on the concept of punishing the offender by imposing a penalty proportionate to the seriousness of the offense. But almost all jurisdictions have felt some necessity to modify this approach,

and they have stated somewhere in their laws that the enforcement of the criminal law shall be "based on reformation and not upon vindictive justice."

As a result, attempts were made to introduce the goal of rehabilitation into penal practice, but it was always seen as subordinate to custody and to other basic policies that had their roots in the older philosophy of vindictive or retributive justice. There is general agreement by most correctional workers that this attempt to introduce rehabilitation has failed and that, for the most part, present-day correctional institutions are mainly breeding places for crime. Sixty-five to seventy-five per cent of individuals going through our correctional systems are recidivists (repeaters), and such figures indicate that the correctional systems neither deter crime nor protect the community except for limited periods of time.

It is becoming increasingly clear that the introduction of experts oriented to treatment does not make a correctional system rehabilitative so long as the old prison tradition remains. What is required is that the old philosophy be discarded, and with it much of the practice that arose from it, and in its place there be developed an integrated system of treatment and security. Most of the leaders in correctional work recognize this, and the movement is now in a state of transition as it is shifting its philosophy, attempting to integrate treatment and security, and getting rid of practices that are really anti-rehabilitative. This shift is accelerating in the light of results from several experimental institutions that have succeeded in integrating treatment and security and have shown themselves to have a much higher degree of success than the traditional institution, with recidivism rates as low as 5 per cent.

Is the physical makeup of the correctional institution conducive to the rehabilitation of the inmate?

Generally not. The majority of prisons were built at a time when the philosophy was that they should look like "dark and comfortless abodes of guilt and wretchedness," according to James V. Bennett, Director of the Federal Bureau of Prisons, writing in the *Architectural Record* of September 1959. He stated that prison architecture has not kept pace with the shifts in correctional philosophy and that, even in current construction, correctional systems too often follow traditions that were already in disrepute one hundred years ago.

What are the qualifications of those persons who work in and administer the correctional institutions?

In some states there are no standards of training and experience required, and political patronage dictates the choice of prison guards and officials. Some systems require high school graduation or two years of college as a minimum. However, those individuals with college degrees in sociology have moved rapidly ahead in correctional systems, and more recently, training in social casework has become important as a way of moving to administrative responsibility. Still, practical experience in a prison, as a guard or supervisor, always carries great weight, and "going up through the ranks" often is more important than any educational or training experience.

Are any specialized personnel employed in correctional institutions?

As correctional systems began to shift their emphasis away from custody, the need for personnel other than guards became clear, and experts in many other areas were brought in as part of the "correctional" team. The first member of the rehabilitation team (and for a long time he was the only member) was the chaplain. Later additions included specialists in education, vocational training, recreational activities, and health services, as well as experts in the administration and maintenance of large institutions.

What type of specialists in the mental health professions practice within correctional institutions?

All members of the mental health professions—especially psychiatrists, clinical psychologists, and psychiatric social workers—now enter correctional work, but their number is pitifully small and they are often poorly trained, according to the standards of their own professional organizations. Even so, over two-thirds of this small number are concentrated in six or seven of the fifty-one correctional systems and the rest have almost none. In 1960 there were less than one hundred psychiatrists working full time or part time in all of the state and federal correctional institutions, an average of one psychiatrist to twenty-four hundred inmates.

What organized activities are available in correctional institutions?

The majority of correctional institutions today feel that the inmates should do more than "pull time" in idleness, and they have de-

veloped programs in education and vocational training. Industrial activity is also organized, but it is considered a privilege rather than a penalty, since it enables inmates to earn a little money. Unfortunately there is not enough work to go around; approximately 40 per cent of the inmates are completely idle, and many of those who do work, don't work a full day.

How is discipline maintained within correctional institutions?

Almost all correctional institutions handle deviations in inmate behavior on the basis of a system of rewards and punishments. There is a general incentive to good behavior in the system of allowing prisoners to earn "good time" (time off for good behavior). On the negative side, there is usually a graded system of punishments for violation of rules. Such punishments may involve reprimand, the loss of certain privileges such as movies or letter writing, the loss of "good time," solitary confinement, and in those systems that have a number of institutions, transfer to a tougher institution, the epitome of which is Alcatraz.

What is the purpose of solitary confinement? Does it have adverse effects on the mental health of the inmates?

Solitary confinement is used as a disciplinary measure when other methods have failed, or in response to unusually serious infractions of rules. It is frequently associated with a monotonous or restricted diet, though very few systems today restrict the diet to "bread and water." Solitary confinement can frequently have an adverse effect, especially if it lasts for more than a few days or if it involves placing the inmate in a dark cell with few contacts with personnel. It is not unusual for a prisoner to lose contact with reality in solitary confinement. This is consistent with the effects of some of the sensory deprivation experiments that have clearly indicated that a sharp decrease in the number of stimuli reaching the individual may lead to psychotic-like symptoms such as hallucinations. (See *Sensory Isolation*)

Do inmates of correctional institutions have any rights, and if so, what are they?

The law relating to the rights of the sentenced offender is vague. Generally both legislatures and courts have been reluctant to limit the discretion of correctional officials, and prisoners, therefore, are largely

at the mercy of correctional authorities. While in prison the inmate's communication with the outside is strictly regulated. He may not telephone, and his mail is censored and limited to correspondents approved by the correctional administration. However, he is given freedom to communicate with his attorney and various government officials, and he has relatively free access to law books, the latter being a significant part of many prison libraries. In addition, as a result of conviction, many civil rights are lost or suspended; for example, the right to sue, to contract and to transfer property, to vote and to hold public office, to testify in court, to perform jury duty, and to retain the rights of marriage, but the specific disabilities vary in different jurisdictions.

Is there much homosexuality in prisons? Why?

It is estimated that between 30 and 85 per cent of all prison inmates engage in homosexual activities during their term, the percentage increasing rapidly with longer sentences. Homosexual activity is encouraged through overcrowding, the lack of opportunity to see and talk to women, and by the general institutional attitude of suppression of everything sexual, the latter out of the assumption that any sexual stimulus, for example, pinup pictures, will encourage homosexual activity.

Why do some correctional institutions allow inmates' wives to stay periodically with their husbands within the institution, or even allow them to stay together temporarily, away from the institution? How many correctional institutions allow such visits?

There are two main reasons for allowing such visits, sometimes called "conjugal" visits. The first is that the correctional institutions have recognized that the older policy of repression of everything sexual creates unnecessary tensions within the institution, actually encourages homosexuality, and as a result hinders rather than helps the rehabilitative process. Second, they have also seen that the possibility of earning the privilege of conjugal visits is a positive factor in the mental health of all of the inmates, not only those who might visit with their wives. Such a policy improves the morale among the men and makes them more resistive to homosexual temptations and pressures within the institution. In the case of those men for whom these pressures and temptations represent a special psychological threat, it can even save many from mental breakdown.

Unfortunately, conjugal visits are permitted officially in only one or

two American correctional institutions, although a few others have relaxed to some extent the degree of guard supervision over the visits of wives and families, allowing more informal and intimate visiting. Mexico and many European countries allow conjugal visits as a matter of official policy.

One of the things that perhaps stands in the way of any great extension of such visits in America is the extent to which the punitive attitude toward prisoners still prevails. The opportunity for sexual expression is seen as something pleasurable and therefore to be forbidden, regardless of whether it is constructive for a prisoner and his family. This objection has been raised to innovations much less controversial than conjugal visits; for example, television or first-run movies.

When released from an institution, are some inmates worse than when they entered? Why?

Definitely yes. They are generally embittered, more cynical, and what is worse, they have more fully developed their antisocial techniques. This arises from the fact that, in spite of humane reforms and the growth of vocational and educational programs, the basic attitude toward the prisoner has not changed. He is not really accepted as a person or treated with genuine dignity. Instead he is seen as an enemy never to be trusted, and so he turns for acceptance to the only ones who accept him—his fellow prisoners—and in turn, he accepts their values. This idea was well put by Donald Clemmer, the director of the Washington D.C. Department of Corrections, in a talk in June 1960:

> ". . . the most colossal of obstacles to success of the behavioral scientist or anyone else, is the present organization of prisons and the nature of the unseen environment in the institution itself. The one nonscientific term that best describes most adult institutions is 'evil.' Evilizing influences prevail in spite of the professional staff and an enlightened and humanitarian leadership, in spite of chaplains, group counseling, and psychotherapy. . . . If one were to search for the most difficult locale in which to effect a modification of a man's character, he would find it in most conventional prisons. The necessary maximizations of custody, for just one element, thwarts the development of self-responsibility and other personality traits which are so sorely needed. The wonder is that any improvement can be wrought in an inmate at all, in the face of all the damaging influences to the contrary."

Should inmates who are considered the best prospects for rehabilitation be kept apart from hardened, habitual criminals? If so, why?

Yes, in the case of the younger more impressionable offenders. But with the increasing amount of group therapy in correctional institutions, it is becoming clear that a price is paid for keeping the best prospects for rehabilitation apart from the apparently hardened offenders. While such a policy may increase the chances for the best prospects, it makes working with the others more difficult. Groups can have potential influence for good, as well as for bad, and to remove all the better men from a group encourages the antisocial thinking of those who are left, since there are then no restraints from their equals. There is now some question among professional workers whether the gain for one group is worth the loss to the other where an institution has a sound treatment program for both groups.

What facilities should exist within the institution to help the inmate morally and mentally? Are these facilities being developed?

The major shift required is one of attitude rather than the addition of new programs or physical facilities, although changes do need to be made in outdated physical plants. Many good programs already exist within correctional institutions—for example, educational, vocational rehabilitation, religious, and counseling programs—but they exist in a setting that is nontherapeutic.

As the various treatment-oriented specialists have entered the correctional scene, a split has developed between the custodial personnel and the treatment personnel, a split that is most marked in the relationship of the mental health professions and the custodial personnel. Each has tended to see the other in stereotyped form, with the mental health people seeing the correctional officers as primarily security oriented, punitive, and antitherapeutic, and the correctional officers seeing the mental health personnel as visionary, easily fooled by inmates, and unconcerned about security. Unfortunately, there have been individuals of each group that have fitted the stereotypes. There have been psychiatrists who have encouraged the inmates to think of correctional people as unfair and abusive, and there have been custodial officers who have poked fun at inmates trying to get religious counseling or psychiatric help.

What is required is an integration of custodial and treatment approaches into a point of view that all personnel can share. An institu-

tion can become truly rehabilitative only when all personnel are committed to all aspects of the institutional program. The program should be one that would allow inmates to face and work with the kinds of problems they had failed to handle prior to their imprisonment and that they will have to handle after their release. These include opportunities for education, for work, for positions of gradually increased authority and responsibility, and for psychiatric treatment if needed. It means placing the majority of inmates in institutions without high stone walls, since only 10 to 20 per cent of them need walls to prevent their escape. It also means an expansion of those programs that bring the men into the community—to go to school, to look for jobs, to visit with their families—before they are finally released. These shifts in program and facilities are gradually occurring, but they are slowed by the reluctance of correctional officials to let professional mental health personnel take the major responsibility for programs involving personality change, and the reluctance of adequately trained mental health professionals to work in a setting where they have no responsibility for institutional policies.

Do all inmates of correctional institutions need psychiatric treatment?

To some extent, yes. All of them have something wrong with them psychologically, in the sense that something inside of them allowed them or forced them to become involved in crime, even in those instances where the crime might have been due largely to social or environmental factors. These offenders need help in finding themselves, in developing stable patterns of behavior, and in changing their attitudes toward society. Although getting this help involves making psychological changes, it doesn't mean that all of them, or even a large number of them, need to have psychotherapy or psychoanalysis.

The most common kind of psychiatric treatment offered to most patients in mental hospitals is the creation of an environment that maintains and encourages the forces leading to mental health. This is the kind of psychiatric treatment that is required within correctional institutions. Just as in most mental hospitals, where the bulk of the treatment is carried on by nurses, psychiatric aides, and adjunctive therapists, the treatment within the correctional institution should be carried on through the correctional officers who spend most of the time with the prisoner. The essence of this treatment is the emotional or the psychological atmosphere that is created. What is crucial is whether the atmosphere is one in which the prisoner can have a close relationship
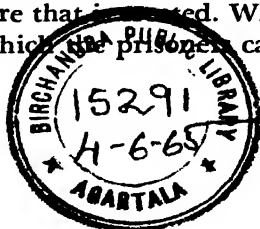
with the correctional officers who represent society, or whether they will have to fight against them as they do in most prisons. In addition to this form of treatment, a small proportion of offenders, perhaps 20 to 25 per cent of them, will need intensive psychiatric treatment—group or individual counseling, drugs, etc. (See *Crime and Mental Disorders*)

How many persons in regular correctional institutions in the United States are undergoing psychiatric treatment of any sort?

A very small number. Since the legal system makes a sharp differentiation between the sane offender, who is sent to prison, and the insane one, who is sent to a state hospital, it has not been thought necessary to offer psychiatric treatment to inmates of correctional institutions. The majority of correctional systems, therefore, do nothing for mentally ill prisoners, except to transfer them to the "criminal insane" units of mental hospitals when they become too disturbed to remain in regular correctional institutions. A few systems, for example, the federal system and that of the State of California, recognize that many convicted offenders are mentally disturbed or become ill in prison, and they have special hospital facilities for the treatment of such inmates. There is also a growing tendency to offer psychiatric treatment or counseling to all offenders, and there are individual and group counseling programs in some correctional institutions. But even so, the psychological atmosphere in the majority of them is still dominated by the old prison policies, and the group counseling is a kind of oasis rather than part of an integrated therapeutic approach to the prisoner. (See *Law and Psychiatry*)

What is the success of psychiatric treatment within the institution?

Those few correctional systems that have the responsibility for treating mentally ill offenders find that when they have the necessary staff, they get results that are at least as good as those of the regular mental hospital. Also, those "criminal insane" units that have adequate treatment programs discover that their relapse rate is considerably less than the recidivism rate of correctional institutions.

With regard to psychiatric approaches to "ordinary" offenders, there are so few institutions that incorporate psychiatric concepts and methods in their programs, that there is no adequate way, as yet, to compare psychiatric methods of treating the offender with traditional methods of treating the offender. The early results, however, seem very promising.

What problems does an inmate's stay in a correctional institution cause for his family?

The most serious problem is the enforced separation that takes place, resulting in an adverse psychological effect on all members of the family. The separation weakens the ties between husband and wife, and makes life more difficult for the children, who need both a father and a mother. The situation is further complicated by financial problems. When the community has to support the family, usually funds are severely limited, and the family lives on a marginal basis. If the mother has to work, she is often forced to leave the children poorly supervised during the daytime, thereby laying the groundwork for later difficulty. Another problem is the stigma that is placed on the family of a "convict" and the resultant rejection, particularly of the children, by neighbors and acquaintances.

How is the date of release from a correctional institution determined?

Basically there are two main methods of release from correctional institutions. The first of these is an automatic or mandatory release that takes place at the expiration of the sentence. Time earned for good behavior has the same legal effect as shortening the sentence, and release after a sentence shortened for good behavior is also mandatory. A second form of release from correctional institutions is selective. An individual whose sentence has not yet expired may be selected for release under supervision (parole), when it is felt he is a good prospect for rehabilitation.

Doesn't the system of automatic release mean that many dangerous offenders are released? Would it not better protect society to detain these men after the expiration of their sentences until they are no longer dangerous?

It is absolutely true that many dangerous offenders are released, but their release at the expiration of their sentences is not a question of choice on anyone's part. They have the right to be released when their sentences are over; this derives directly from the punishment concept of imprisonment, the idea of "paying a debt" to society. While it would certainly give society better protection to keep these men "locked up" until they are no longer dangerous, the state has no authority to do so at the present time. It is questionable whether the state could get this authority unless the entire philosophy behind the handling of offenders

changes to something resembling the civil commitment and treatment of dangerous mental patients.

What is parole? What effect does it have on the mental health of the individual?

Parole is a method by which prisoners are selected for release on the basis of their individual response to the program offered by the correctional system, and also a service by which the inmate is provided with supervision after his release from the institution. Parole, therefore, is a key to the effective functioning of any correctional system. Its purpose is to prevent an individual from staying in a correctional institution too long, since this is detrimental to the individual and needlessly expensive to the community. A well-functioning parole system generally has a very positive effect on the mental health of all inmates. It serves to give hope and encouragement to those in the institutions, and it encourages self-respect and the assumption of maximum responsibility in those who are functioning on the outside under supervision and guidance.

Shouldn't all prisoners be supervised after their release?

Definitely yes. But the correctional system or the parole system currently has no authority to supervise prisoners after the expiration of their sentences. Therefore, the men who might need supervision most—those with long previous records, poor institutional adjustment, etc.—usually fail to get any supervision. This gap in the law has occasionally resulted in paradoxical action by correctional officials who have released some men a short time before the expiration of their sentences, even though they didn't "deserve" it, so that they could have the opportunity of some supervision by parole officers before they were left entirely on their own in the community.

What is probation and how is it different from parole? How successful is it as a method for handling offenders?

Probation is a procedure under which a defendant, after a finding of guilt, is released by the court without imprisonment, subject to the conditions imposed by the court and also subject to supervision by the probation service of the court. In concept and practice, it is similar to parole, except that it bypasses the institutional side of the correctional system. Like parole, it depends for its success on the training and the

qualifications of the supervising officer. When the proper choices are made, based on adequate pre-sentence investigation, and when trained personnel supervise the probationers, under conditions of reasonable time for the cases, probation is successful in 80 to 85 per cent of the cases.

Why, and under what conditions, are sentences commuted and pardons granted, and what effect do these have on inmates?

These are forms of mercy or clemency exercisable by the President in federal cases and by the governor in each of the states. Their purpose is to provide flexibility in the administration of the correctional system when special circumstances arise, such as an unduly harsh sentence, a serious question about the prisoner's guilt, special personal or family hardship. Pardons are sometimes used to restore civil rights to former prisoners. Executive clemency has an important role in an integrated correctional system, but if it is used capriciously or on a political basis, it hurts the morale of inmates and undercuts the entire system.

What are the rehabilitation problems a prisoner must face after being released from a correctional institution?

The major problem is acceptance by the community, and this is reflected mainly in the employment difficulties the released prisoner always faces. Difficulty in getting a job is his greatest single problem. A second problem is lack of acceptance on a social level. "Decent people" don't want to have anything to do with an "ex-convict"; this pushes him to associate with his old' companions, the only ones who seem willing to accept him. A third problem is that he has to make decisions about things that once were decided for him, for example, what to eat, what to wear, how to use his leisure time, etc. Another problem is the fact that those who have served long sentences find that certain aspects of the outside world are unfamiliar, for example, changes in automobile transmissions and clothing styles.

Are there any organizations that work with the released prisoner and his family in the rehabilitation process? How valuable is their help?

There are no organizations primarily oriented to helping the offender become rehabilitated, as Alcoholics Anonymous is with alcoholics, although from time to-time there have been abortive attempts to form such organizations. There are many community agencies, how-

ever, that participate in the rehabilitation process, and some of the most important of these are: family service agencies, departments of public welfare, mental health clinics, the American Red Cross, the Salvation Army, and the Y.M.C.A. It is difficult to generalize about their specific effect, since they do so many different things. Without them, parole and probation officers would be very handicapped and their percentage of success significantly diminished. Also, by their very nature as community agencies, their working with the offender and his family helps bridge the gap into the community.

What research is being done in the field of psychiatry and corrections, and how could it contribute to improved methods of rehabilitation of prisoners?

There are two main types of research going on. One relates to improvements in methods of diagnosis and treatment of patients who have behavior disorders, and the refinement of ways to predict future behavior (prognosis) with or without intervening treatment. These research studies involve patients individually and in groups in all types of settings where psychiatrists work, including private practice, community clinics, and mental hospital settings.

The second type of research has to do with the application of methods already demonstrated successful in psychiatric practice, to correctional settings. This type of research, in a sense, is more important than the first, because there are already many techniques for the successful rehabilitation of a large proportion of offenders. The problem is to demonstrate that these techniques also work in correctional settings, so that the community can recognize the tremendous waste, both in people and money, of not using known methods of rehabilitation.

How can people in the community help the correctional system do a better job?

The main thing is to become informed about the various issues involved in correctional work, and on the basis of this informed knowledge, to support legislation and administrative policies designed to make correctional systems more rehabilitative in their outlook. This can be done through lay membership in the National Council on Crime and Delinquency, 44 East 23rd Street, New York 10, N.Y., or the American Correctional Association, 135 East 15th Street, New York 3, New York. Both of these organizations have been active in community education and the formation of local citizens' councils. In addition, citizens

might become members of one of the various prisoner aid societies, which work closely with the professional associations and the correctional systems within the states. (For a list of these societies, write the International Prisoners Aid Association, 125 East Wells Street, Milwaukee 2, Wisconsin.) Finally, individuals in the community could also participate in the rehabilitation of specific individuals by sponsoring men on parole or offering jobs to them where they are otherwise qualified, and thereby help combat the irrational fear about "ex-convicts."

COURTSHIP AND ENGAGEMENT

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What is the difference between dating, courtship, and engagement?

Courtship is the process of mate selection. Dating is a sort of screening stage of courtship, as well as having as its own goal a good time, gaining status with one's peer group, and learning to get along with the other sex. Casual dating (even steady dating) does not necessarily involve serious consideration of the other as a possible mate.

The term "courtship" usually implies that at least one of the two people is seriously considering the other as a marriage partner and is trying to elicit a reciprocal response. Among older teen-agers and young adults, steady dating usually implies a deepening relationship. "Pinning" (presenting a girl with a fraternity pin as a pledge of affection) has developed into a sort of tentative engagement to become formally engaged if they continue to feel as they do when marriage becomes possible. It is not so binding as a formal engagement, and hence not so frightening to parents. Pinning carries some social recognition from the peer group, but returning a pin is not as serious as breaking an engagement. It is felt by many that pinning may reduce the number of broken engagements by serving as a testing period.

Engagement is considered a firm intent on the part of both to marry, and to limit dating to each other. It is still a period of testing the relationship, the other's family, common goals and attitudes, etc. Financial status, attitudes toward sex and children, degree of religious commitment, etc., are weighed by the individuals and their families. The fact that from one-third to one-half of all engagements are broken indicates that engagements are not as final as many young lovers assume.

Much anxiety and personality damage occurs because of the lack of more definite landmarks on the road to marriage. For example, girls are twice as likely as boys to consider themselves "engaged" when they are pinned. Some boys use pinning as a technique for encouraging premarital intercourse because of the greater tendency of engaged girls to permit it.

What is the difference between infatuation, physical attraction, and maturing love?

Infatuation may occur when one meets a person who seems to fit the idealized image of the person one hopes to marry. Or it may be that young people are normally so unsure of themselves as they begin to try to act adult, that they overrespond to anyone who treats them like an adult. Since girls mature earlier than boys and have fewer obstacles to marriage, an infatuation usually begins with a girl deciding she likes a boy and letting him know it. This makes him feel wonderful, so he thinks she's wonderful. Also, being desired as a partner gives both of them status with their peer groups. Acting as they have seen adults act (mostly on movie and television screens) makes them feel very adult and very good about themselves and each other. Trouble occurs when one or the other, because of preoccupation with his own emotional needs, lacks consideration for the other. The ego is hurt and the growth cycle turns into a vicious cycle unless one or both are mature enough, and care enough, to say, "I'm sorry"—two of the most important words in our language.

Physical attraction has played a larger role in mate selection—and in divorce—since the automobile scuttled chaperonage and gave young people the privacy to make necking and petting favorite "outdoor sports." In her need to assure herself that she is attractive and lovable, the adolescent girl often permits, or even encourages, affectionate exchanges. If this is continued for more than a few minutes, the intimacy tends to stimulate both of them sexually. But because the girl's response is "generalized," while the male's is "genitalized," what she experiences as love, he experiences as sexual desire. If this necking progresses to petting, she learns to experience sexual desire also. This confusion of love-sex feelings leads some young people into premarital intercourse. Others, whose idealism prevents this, are often hurried into marriage. Young people must be educated to understand these differences in sexual and emotional responses so that they neither drift into sexual intimacy nor rush into marriage. Learning to limit affection gives love a chance to mature and prevents much heartbreak and ego damage during adolescence.

Maturing love implies an increased capacity to care about the happiness and well-being of another person. Young people who take time to "grow to love" each other usually have more successful marriages than those who "fall in love" as a result of infatuation or physical at-

traction, although there are elements of both in all love relationships.

Growing to love implies taking time to really learn to know another person, his background, his beliefs, and his attitudes, etc. Getting to know his family, and seeing him interact with them, helps greatly in understanding him. The boy who has a good relationship with his mother, and the girl who is fond of and respects her father, tend to relate more comfortably to someone like them. On the other hand, if there is a poor relationship with the parent of the other sex, the person may unconsciously be attracted to someone of opposite personality. For example, a girl who resents a dominating father may choose an indecisive man who lets her dominate the relationship, and then she may resent his inability to make decisions.

Growing to love implies increasingly realistic acceptance of the other as he is, sensing that one is strong where the other is weak, and weak where the other is strong, so that they need each other and develop a mutually satisfying largely nonsexual companionship, to which the sexual intimacies of marriage can be added.

Is modern courtship responsible for our high divorce rate?

Partly, but many other factors in American culture also contribute to it. What happens too often is that earlier dating, plus the increase of physical intimacy made possible by the automobile, rushes young people too rapidly into marriage. The romantic version of love at first sight, so common to story, stage, and screen, adds fuel to the fire. So do a more permissive pattern of child rearing and higher living standards, which lead youngsters to expect to get just about anything they want. The greater availability of jobs for women and the greater acceptance of student marriages by both schools and parents encourage hastier marriages. Increased academic pressure at all levels of education may be causing many young persons to escape the pressure and lack of academic success via early marriage. The greater acceptance of drinking by women has probably contributed to an increase of unwise involvements leading to unworkable marriages.

It is not really accurate to say that one out of every four marriages will fail just because there are about one-fourth as many divorces as marriages. Emotionally immature and neurotic individuals who repeatedly divorce and remarry distort the picture. But there can be no doubt that a culture pattern that requires adolescents to make decisions regarding dating behavior and mate selection puts a strain on human

emotions that is not present in cultures where young people are chaperoned and marriages are arranged by parents. This is not to suggest that we return to such a system. What is implied is that we must give our young people a more adequate education in the area of dating, courtship, and marriage so that they may make wiser decisions and fewer false starts in marriage and family life. (See *Emotional Problems of Divorce*)

Can courtship be maintained or culminate in marriage with only physical attraction? Without physical attraction?

Physical attraction is one of the chief causes of hasty or early marriage. Research indicates that in marriages between high school students, sexual intimacy or pregnancy may have precipitated as many as half of such marriages. It is probably safe to say that because of the difference in response to, and meaning of, intercourse to men and women, few relationships are strong enough to indefinitely continue a predominantly physical relationship outside of marriage. Alfred C. Kinsey's data indicate that where intercourse has preceded marriage, it was usually only for a short time before the marriage.

It is probably equally true that normal friendly affection, dancing, and just the physical proximity of dating and courtship produce a considerable degree of physical attraction, motivating both male and female toward marriage. Far fewer men would assume the responsibilities of marriage were it not for their insistent and persistent sexual desires. Some women, on the other hand, are likely to marry without conscious sexual desire, or even with some aversion for sex. Lack of desire indicates a need for premarital or marital counseling. (See *Sexual Relations and Marriage*)

What problems does the double standard of sexual morality create for males and females?

Men have always enforced upon women a sexual morality they do not themselves practice. A very basic reason for this is that the woman knows her child is her own; a man can only have faith that the child is his. To ignore this basic biopsychological fact is to court disaster, and some think that women, in a great rush to acquire equality with men, have done just that. In fairness, women ought to have as much right to sexual experimentation as men, and in fairness, men ought to bear half

the children. Since they never will, two standards of morality will probably continue.

Parents reflect their recognition of the two standards in their greater concern about their daughters' sexual behavior than about their sons'. The entire marriage and family system is rooted in sex differences—both physical and psychological. Some think that in recent years women are not so much striving to act like men as to be "equal but different," which is a healthier attitude, and gives women a more creative role.

Is premarital intercourse increasing?

Kinsey's data indicate that the percentage of girls having premarital intercourse increased sharply during the 1920's with the popularization of ballroom dancing, the automobile, and the decrease of chaperonage, but has remained relatively constant since then. Love seems to be a factor with about 87 per cent of the women who have premarital intercourse (about half of all women studied by Kinsey). Roughly half of these women had intercourse only with the man they later married. Another 41 per cent had intercourse with one or more other men before having intercourse with the man they later married. Thus only a small group of girls—probably no more than 15 per cent—serve as the sex partners of the estimated 75 per cent of the men who have intercourse with a woman other than their fiancée.

Kinsey found that the percentage of young men having premarital intercourse has increased very little. They are less likely to have premarital intercourse with a prostitute, and have it more frequently with social dates or "pickups."

Is there any recent research that deals specifically with the sexual aspects of dating?

Winston Ehrman's *Premarital Dating Behavior*, a study of college girls, reports that girls have limits to the degree of intimacy they permit, ranging from holding hands to kissing, to necking, to petting, to heavy petting, and to sexual intercourse. Continued dating with one partner tends to encourage more intimacy. When the girls change partners, they tend to start the new relationship at the level of intimacy permitted with the previous partner.

Lester Kirkendall's *Premarital Intercourse and Interpersonal Relationships* reports on interviews with two hundred college men who had

intercourse before marriage with women ranging from prostitutes to pickups, to casual dates, to friends, to fiancées. His data confirm the concept that as men care more about a girl, they show more considera- tion for her and make less demands upon her sexually. Some of the engaged men discontinued intercourse when they found that it put a strain on the relationship.

Both studies give evidence of the tendency of men to use love to get sex, and women to use sex to get love. A student from the Near East (where parents still arrange marriages) described college courtship in America as a sort of "cat and mouse game in which the girls are trying to get the boys into church, and the boys are trying to get the girls into bed."

How does premarital intercourse affect courtship? Marriage?

One of the most harmful effects of premarital intercourse is the damage it often causes to the relationship. The guilt feelings that almost inevitably result from the unequal risk and satisfaction involved in the intercourse, plus the anxiety related to parental and social dis- approval, plus the possibility of pregnancy, are often transformed into hostility for the person considered responsible. The relationship may be broken, hurting both persons. Or these same feelings may motivate a hasty marriage to a person for whom respect has been lost, almost assuring marriage failure.

In American culture, most boys learn about sex through sexy stories told by other boys, and tend to divide women into two groups: the promiscuous type that one exploits if possible, and the "nice girl" one plans to marry. Apparently, when the girl "gives in" to his desires, he unconsciously transfers her from the group of nice girls to the other group. He then begins to find faults in her to justify not marrying her. His guilt feelings are converted into hostility toward her, in effect saying, "If you had refused me, as you should have, I wouldn't have these guilt feelings." She is hurt and resentful, and this further alienates them. Often they either break off the relationship entirely, or she may use his guilt feelings to promote an early marriage, only to have him feel later that he was trapped into marriage.

In his study, Kirkendall found that some of the men felt intercourse had strengthened their feelings for their partners and had led to happy marriages. Kirkendall questioned whether this was true, or whether the relationship was already so strong that they psychologically accepted

each other as life partners, whether engaged or not. L. M. Terman's study, like nine others that preceded it, showed that the most happily married couples had not had premarital intercourse. But he found that the women who married the only man with whom they had had intercourse, seemed as happily married as women in general.

What are the pressures of courtship?

Some pressures are present in all motivation to act—including acting more adult. Cultural pressures to reserve intercourse for marriage add motivation to men's desire to marry, and social pressures and security needs increase women's urge to marry. Not all pressures are unwholesome.

Unwholesome pressures seem to be some of the following:

1) The social pressure on girls to prove their feminine attractiveness by dating, pinning, and becoming engaged while still in school. This is caused, in part, by the mass advertising of products guaranteed to increase feminine charm, and, in part, by parents who want their daughters "to rate" and are torn between a desire to discourage and at the same time to encourage, steady dating. This pressure on girls to select a mate seems to make getting an education secondary, and their studies suffer. Also, since the most serious boys are preoccupied with preparation for a vocation, girls often become involved with the less responsible and less desirable males. The fact that girls mature faster than boys and are ready for marriage earlier intensifies the problem.

2) The pressure to date, to go steady, and to become pinned and engaged before one is emotionally ready for such important decisions. This causes such individuals to seek security by conformity to the behavior of the group, to be guided by social approval rather than by personal conviction.

3) The pressure that boys put on girls to make sexual intimacy the price of a continuing relationship. Lower-class girls or girls with a poor self-image often accept this as the only road to marriage, and even attempt pregnancy to ensure an early marriage. According to a study by Harold Christiansen, forced marriages appear to fail about twice as often as the average.

4) The pressure on young adults to marry as the solution to all their emotional problems. This together with the romantic expectation that they will "live happily ever after," leaves both newlyweds

unprepared for the multiple adjustments that marriage demands of every individual who makes a success of it.

How can these pressures be reduced?

The pressures of courtship can be reduced by:
1) An organized effort to intensify the study of human relations and the psychology of personality during the junior and senior high school years. Students are intensely interested in these areas during these years, and required courses in English and literature lend themselves beautifully to such studies, once teachers are trained. The public will have to be convinced that the science of human relations is just as important as the physical sciences and mathematics.
2) An organized effort to attach social status to group leadership and membership rather than to individual dating. Young people who have good experiences in Hi-Y and TriHi-Y, advanced Scouting, church groups, etc., meet their emotional needs in ways that reduce the pressure to date and become intimately involved.
3) A genuine attempt on the part of parents to encourage their youngsters to have strong friendships with members of their own sex group. This means sincerely welcoming youngsters into homes for meals, overnight visits, on trips, etc., and having courage to let youngsters spend time in their friends' homes. There seems little reason to fear that these intimate relationships will become substitutes for, or blocks to, normal heterosexual relationships when the individual is emotionally and economically ready for serious courtship.   •
4) Educating our girls to realize that "girls set the standards of sexual morality," and teaching our boys to respect and date girls with good moral values. Teaching girls how to become affectionate and loving women without unnecessarily stimulating boys—or themselves—is one of the most challenging tasks for our generation.
5) Assuring our young people that getting a good education is important for both boys and girls; that taking time to grow up educationally and vocationally before becoming too involved romantically or sexually seems to pay off in a wiser choice of both vocations and mates; that a sincere effort to grow to really understand an admired and loved member of the other sex can be an exciting and rewarding experience that can last a lifetime. (See *Adolescence*)

Can one continually choose "the wrong person" as a potential mate?

Yes. We probably choose as our mate (or are attracted to) someone who seems to meet our unconscious emotional needs. The need to feel good about ourselves, to feel that someone cares about us, the need for adventure and variety in life, the need for faith and security, and the need for a sex partner are among the strongest needs of the healthy personality. To the degree that each partner satisfies these needs of the other, the marriage may be said to be successful and happy. But some individuals have neurotic needs that make for conflict. The "spoiled" individual, who needs to dominate his wife as he did his mother, marries someone who may let him have his way before marriage, but soon tires of that after marriage. The person who has difficulty making decisions may be attracted to someone who makes decisions easily, only to discover after marriage that these decisions are often impulsive and not logical, causing the one to lose confidence in the other. Because a wife, for example, is unable to make decisions herself, and is fearful of her husband's, conflict ensues. Still more serious is the situation where an individual is motivated by unconscious feelings of guilt because of perfectionist parents. This individual literally seeks punishment from the spouse, unconsciously, but consciously resents it. Thus most serious marital conflict is found to have its origin in inner conflict within one or both of the marriage partners. Good marriage counseling must often include psychotherapy, if these basically unhappy people are ever to become happy people capable of enjoying marriage, work, or life itself. (See *Marriage Counseling*)

What are the social, religious, educational, or economic factors in the successful mating of individuals?

Contrary to the psychological values where a person seems to be most happily married to someone who is weak where he is strong, and strong where he is weak, so that they need and help each other, it seems desirable for people to share basic social, religious, educational, and economic values.

Each individual takes on—or rejects—the values of the group in which he matures. The more he feels accepted and loved by his parents, the more he absorbs their values. The more he is rejected or criticized by them, the more he rejects their values. Nearly all youngsters seem to reject their parental values for a period as they go through adolescence, but they are not so much rejecting parental values as experimenting

with other values, particularly those of the peer group. Parents often react by criticizing and exercising their authority. Some teen-agers fearfully conform; others openly rebel. Minority group teen-agers often get into trouble because they rebel both against parental and majority group values. Early marriage is often a rebellion against family and group values, and this probably accounts for some of the failures of early marriages.

All marriages are "interfaith" marriages to some degree, for our real "faith" results from our life experiences, and no two people have the same experiences. People who grow up in the same religious group are likely to have more experiences and beliefs in common. But difference in religious devotion by two people of the same faith can also be a serious problem. All marriages have difficulties. "Interfaith," international, interracial, or interclass marriages have all the problems of the typical marriage, plus the special problems of their differences.

Educational similarity is also desirable. But perhaps somewhat equal ability is even more important. Statistically, women who marry men with considerably less education are among the most unhappily married women in our culture. Exceptionally bright girls have a hard time finding a man who will respect rather than resent them. In part, this may be due to a school system that forces boys to compete with girls who are more mature than they are during the elementary and junior high school periods. When the boy starts dating, it is usually with a younger girl. The early developing girls and late developing boys have the hardest time feeling "accepted," and we must give more thought to easing their adjustments.

Money problems are among the most common in marriage. There is never enough money to satisfy all desires, and unless the couple learns to cooperate in the spending of it, there is trouble. Each partner has grown up in a family that has chosen to spend its money to satisfy certain values, and each tends to feel that this is the proper use of money. Families with different incomes tend to value different things, and so do certain ethnic and religious groups. If a person marries someone with values similar to his own, there is likely to be less conflict in the use of money. It is naturally easier to adjust upward to freer spending than downward to curtailment of spending. Most young couples have to adjust downward because the husband's earning power does not equal that of their fathers. If both husband and wife work, they may be able to maintain their high spending patterns. But when the wife becomes pregnant and they are cut to a single income at the very time that

all basic expenditures are increased by the growing family, they may be in for real trouble, particularly if they are heavily in debt because of installment buying. If the child was unplanned, or is unwanted, the parents may unconsciously resent his coming and the drastic change it makes in their way of life. This may be part of the "first child problem" that is fairly common in our society. (See *Marital Problems and Marital Adjustment*)

Can a parent's desire to influence his offspring's choice of a marriage partner have an adverse effect?

All parents probably influence their sons' and daughters' choice of mates. By the approval or disapproval the parents express, either verbally or nonverbally, young people sense parental reaction to their friends and "dates." During their offspring's struggle for independence, and during the period when they are "trying out" types of personality other than those in their family, parents often fear that these temporary infatuations may develop into serious courtship. In some families the father gets himself transferred to another area, or the son or daughter may be sent away to school in the hope of breaking up the relationship. Such interference at times brings resentment, and increased loyalty to the partner, with the result that some young people elope. In rare instances, a premarital pregnancy may be the youngsters' way of defeating the parents.

Marrying without parental consent, and eloping, seem more frequently to be preludes to unhappy marriages and divorces. True, sometimes there are neurotic parents who frustrate their children's choice of mate. But more frequently, parents desire what is best for their youngster, and are more perceptive than romantic teen-agers, so it seems safe counsel that young people take more time and try to win their parents' approval. Once the couple has announced the engagement and set the date, parents should do everything possible to give support to the marriage, or they must share the responsibility for its failure.

What are the problems of young people who remain virgin until marriage?

Girls who avoid prolonged necking or heavy petting with boys who are seeking sexual stimulation from their contacts with girls, probably do not experience too much sexual desire. Girls apparently learn to experience sexual stimulation and sexual desire through repeated physi-

cal stimulation. Girls who learn to experience sexual desire through prolonged or intimate physical contact, but who resist total intimacy because of moral convictions, probably experience considerable strain and guilt feelings. If they continue this relationship they tend to get more and more deeply involved, both as a result of their desire to please the man for whom they feel a growing concern and as a result of the growing intensity of their own sexual desires. This combination of feelings usually leads either to marriage or sexual intimacy outside of marriage. An increasing number of couples, particularly among the college group, are indulging in "petting to orgasm" but still refraining from intercourse. This has developed so recently that little or no research upon the effects of this pattern is available. It is probable, however, that few men are satisfied to continue this relation long, and their increasing insistence upon complete intimacy will either break down the girl's resistance or break up the relationship.

Almost all boys develop intense sexual feelings much earlier than girls. Since boys are more easily stimulated than girls, most boys discover autoerotic satisfactions very early in life. Masturbation is practiced by most after they become capable of orgasm, but the rate varies from a few times a day, to a few times a week or month, depending on the boy. Kinsey's studies pointed out that the average boy had probably experienced orgasm a thousand times before marriage—the average girl, never. With the increased acceptance of masturbation as a form of sexual release, boys should have less difficulty with sexual tensions, provided the fantasy accompanying it is oriented toward love and marriage rather than toward promiscuity.

Men and boys have fewer sex tensions when they have intense interests such as cars, athletics, science, photography, or a future vocation.

What degrees of sexual intimacy are sanctioned before marriage?

That depends upon the group and the individual. Mothers (who really determine the mores of a group) in lower socioeconomic groups hope their daughters will refrain from premarital intercourse, but are very much afraid they will become involved sooner or later. They hope their daughters will not become pregnant, or if they do, that the man will marry them.

Most middle-class mothers do everything possible to get their daughters to refrain from intercourse, although they expect them to do a

certain amount of necking. They warn them to "draw the line" at prolonged parking and petting, and encourage them in many ways to "finish their schooling," whether that be high school or college. They experience acute social embarrassment if their daughter becomes pregnant, and if possible, arrange a hasty marriage to conceal the fact from relatives and friends.

In general, premarital intercourse is less acceptable and less frequently practiced by people with strong religious convictions, with more education, with a higher standard of living, with aspirations for future achievements, and who grow up and live in stable and happy families.

The majority of young people studied, approve of kissing and other expressions of affection on dates. They permit engaged couples greater freedom of expression of affection, and even mild petting. They do not condemn premarital relations, but neither do they approve. Like the rest of society, they apparently see no way to approve "a little intercourse" any more than they can approve "a little pregnancy." Once started, both seem to progress to more serious outcomes.

American culture puts heavy demands on young people. We give them freedom to be alone together, we permit the spontaneous expressions of affection they feel for each other, but we expect them to draw the line short of serious sexual involvement. The difficult role we assign the girl is that of learning to become a loving woman without sexual involvement.

At the same time, we permit the sixteen-year-old boy the privilege of having his own car, dating, and necking with girls in his car, but we expect him to avoid becoming so involved that it interferes with his pursuit of education and vocational competence, after which we permit him to marry. The surprising thing, perhaps, is not that many boys and girls become prematurely involved, but that so many wait until they are ready to marry.

What is the purpose of a formal engagement? How long should an engagement period be?

When two young people announce their engagement, they are telling their families, their friends, and the world that a new relationship exists. The more personal problems can now be talked about and plans can be made. They seem to need to get used to the idea of "belonging together" before they have to live together twenty-four

hours a day. Each has a new status as a family member in the other's family, and both of them need time to become members of the larger family of in-laws. Taking time to court the family and relatives probably reduces in-law problems later.

Another factor in the period of engagement is that mothers need time to plan the wedding. This is one of the rewards that make up for many of the problems of rearing a family. Taking the time to plan the wedding and trying to fit together everybody's dream makes it possible for both mother and daughter to be "queen for a day" and come through it as two adults who can enjoy each other in a mature way.

Statistically, the longer the engagement, the better, up to two years. But it is not really "how long" the engagement lasts that is important, but how well the young people get to know each other as future husband and wife. If they have known each other a long time, the engagement can safely be shorter. Few divorces occur when the two people have gone steady for a year and then have been engaged a year before marriage.

For two people who see a good deal of each other, an engagement of more than a year can become increasingly frustrating. The longer they are together, the more intimate they tend to become, the more affectionate, and the more passionate. Those who of necessity face a long engagement must learn to limit their intimacy and the amount of time they spend with each other alone.

Does engagement change attitudes about premarital intercourse?

For more than half the women who enter marriage as virgins, apparently not. But they may have married the type of men who really loved and respected their feelings, and did not pressure them to have premarital intercourse.

On the other hand, Kinsey found that about half of the women who had premarital intercourse had it only with the man they married, shortly before marriage. An almost equal number had intercourse with their fiancés, but they had had previous experience—perhaps with former fiancés. In a study of engagements, Evelyn Duvall found that between one-third and one-half of all engagements are broken, and that conflict over sex is given as the reason more often than any other. Marriage counselors sometimes find that some couples seem to have lost some of their love for each other even before marriage, but married anyway because of guilt feelings or obligations to marry because of

sexual intimacy. Premarital intimacy probably precipitates many marriages too hastily, not allowing time or interest for the consideration of the many psychological, educational, and economic factors that make for stable marriages.

Is there an increasing rate of pregnancy among engaged couples? How does this affect the individuals and the marriage?

The number of known illegitimate births has increased steadily, but it is very hard to sort out any statistics that indicate pregnancy figures for engaged couples. What is perfectly obvious to counselors, however, is that an unplanned pregnancy before marriage upsets the normal progression of the growth of love and adjustment to each other, and centers most of the attention on preparing for the coming child. For example, ideally, a young man and young woman go together for a year, become engaged for a year, marry, and have a year or more to become adjusted to each other and to become financially stable before they start their family. But when a girl discovers she is pregnant, engaged or not, the tendency is to short-circuit all previous plans and rush to a justice of the peace in a community where delays are minimum. Gone are the plans for a beautiful church wedding with the gala support of friends and relatives. Of what significance is the honeymoon in such a marriage? Gone are the woman's plans to finish school or to work on a job before starting a family. The couple faces a host of problems, for which they all too often blame each other. Harold Christiansen's study indicated that marriages, in which a child was born less than eight months after the marriage, ended in divorce twice as often as the average. How many of these couples had been engaged at the time, it was impossible to tell.

Is there a high rate of abortion during the engagement period?

Because abortion is illegal, there are almost no reliable figures available. It is well known that most abortions are performed on married women who already have families, and on frightened young girls.

Counseling experience would indicate that engaged women are likely to resent a fiancé's suggestion that an abortion be performed. In such a situation, probably most engaged women would refuse and insist on immediate marriage instead. Such backgrounds are not uncommon in cases seen by marriage counselors. Undoubtedly some abortions are performed on engaged women, but it is doubtful that the rate is high. (See *Abortion*)

CREATIVITY

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What is creativity?

Creativity is the ability to bring something new into existence. This "something new" may embrace a wide variety of forms: a novel solution to a problem in mathematics, a mechanical invention, a chemical process, a poem, painting, or musical composition, a new form of architecture, an innovation in law, a new treatment for a disease, a fresh way of thinking about social problems—the list could be almost endless. The emphasis in all these is upon originality, upon the production of that which can be considered fresh, novel, unusual, ingenious, divergent, clever, and apt.

Does everyone have a creative drive?

It would perhaps be pleasant to think so, but if we take a candid look at most of the adults around us, we are forced to conclude either that many people do not have a drive to create, or that whatever natural creativity they may have had as children has been stifled in them. On the positive side of the question, however, it should be noted that a little encouragement often brings out in people an unsuspected ability to create. In most children we see far more natural curiosity and spontaneity than in most adults, hence it is perhaps not unfair to conclude that something happens to a person's creative drive under the pressures of earning a living and of becoming part of a vast routine.

Is creativity a sign of high intelligence? Of genius?

This depends to a large degree upon how novel or how original we require a product or action to be in order to call it creative. For example, the theory of relativity was highly original, and there is no doubt that only a person of genius intelligence, such as Albert Einstein, could have produced it; even to grasp the antecedent problems, much less to come forward with the original solution, required high intelligence. On the other hand, creativity is not a product of high intelligence alone. It is said that Thomas Huxley, the famous English

biologist, upon first hearing Charles Darwin's theory of natural selection, exclaimed, "Now why didn't I think of that!" Huxley probably knew the biological facts as well as Darwin did, but the theory did not suggest itself to him. High intelligence is usually a prerequisite for creative acts of unusual elegance and originality, but if we relax the standards of what we call creative, then it is apparent that persons of average intelligence may be creative on their own terms; for example, a housewife preparing a new dish, a carpenter figuring out a new way to shape boards to one another, a clergyman making a parable of his own, or even a confidence man thinking up a new way to cheat the unwary. It may be said in general that intelligence is a help to creativity, but that it is not the whole story. Recent research by educational psychologists indicates that in addition to an I.Q. of about 120, certain other traits of personality and motivation are more important than what is measured by an intelligence test. The traits of personality and motivation, which become important in the I.Q. range above 120, include the ability and motivation to work independently and autonomously rather than in a conforming manner, a high level of general energy, a drive to make sense of contradictory or diverse facts in a single theory or perception, and flexibility of thought and action.

Why do some individuals not use their creative potentials?

Failure to use one's creative potential may be due to a variety of reasons. The process of socialization, if it puts too much emphasis on conformity and the "right" way of doing things, may cause a loss of flexibility, adventuresomeness, and willingness to experiment. To be original means to be different in some important way, and sometimes it takes courage and daring to be different from those around us, especially if our society puts a premium on "getting along with the group."

There are many other fears that can be inhibiting to creativity: fear of failure, fear of ridicule, fear of becoming personally unbalanced if we entertain those "crazy hunches" that are often enough the beginning of a new way of looking at things. To this might even be added "fear of having fun with ideas," for there is a certain playfulness about the creative process, a willingness to make light of what is usually taken seriously.

In addition to inhibiting fears, there are, of course, other causes for the loss of creative potential: being caught up in routine, being too self-absorbed and worrisome to have any energy left for doing some-

thing new, feeling hopeless about changing anything, and so on; in brief, almost the whole catalog of the symptoms of a neurosis that constricts our vision of new possibilities.

Does creativity alter in the aging process?

This depends in part upon the sphere of action or ideas in which the individual is creative. Most creative persons are creative all through their lives, and the most astonishing thing is the sheer volume of work done by persons who are especially known for this or that particular contribution. Persistence unquestionably plays a large part in the drive to create; it is strong and almost continuous, even though there are periods when good ideas do not seem to come, and when the well of inspiration seems to have run dry. The very best ideas do show some relation to age, however, depending in part on the person's field; for example, in mathematics, and in lyric poetry, the best work is usually done in the late teens and early twenties; in the writing of novels, on the other hand, the best work is done in maturity, even late maturity or old age. In the physical sciences, the peak is reached, so far as really outstanding contributions are concerned, between the ages of about twenty-six and thirty-two. Nevertheless, many, many works of unquestionable genius have been performed at all ages up to eighty or eighty-five. But, works of genius aside, the potential for creativity may remain in all of us—in terms of our own abilities and interests—throughout our lives.

Why are aging persons often encouraged to take up creative activities after retirement?

Very often an individual puts aside a creative interest for a period of years while he is involved in the bread-and-butter tasks of setting up a home, supporting his family, making his way in his chosen field of work; then, with retirement and suddenly increased leisure, he finds it possible to return to that interest and to find a fuller self-realization than he had believed possible. It is often surprising what a person can do creatively when deadening routine has lost its hold upon him.

Is there a certain age at which genuine creativeness can be distinguished from the inventiveness that so many children have?

A considerable amount of training and discipline is usually necessary for highly creative work, such as musical composition, problem-

solving in mathematics or physics, ballet dancing, painting, architecture, and many other endeavors. Moreover, such work is generally directed toward an audience capable of understanding and receiving or appreciating the work, while children's inventiveness usually is not. Thus a certain amount of maturation of the talent, and discipline in its exercise, must precede its full expression. Since this also takes time, the genuinely creative act can be expected to occur only rarely in childhood or before maturation has taken place. Still, as emphasized previously, creativity shows itself through a very wide age range, and it is not age itself that is considered important.

Is an unhappy environment more likely to produce a creative individual than a happy one?

It is not always easy to tell whether an environment is a happy or an unhappy one—what makes for happiness in some people makes for unhappiness in others. And who can say how many people are happy, or who they are? The question is difficult to answer unequivocally. Still, some general considerations may be noted. When the environment is a lively and complex one, providing varied opportunity for expression and personal involvement, it seems to stimulate flexibility and spontaneity in the people who are part of it. Ancient Greece, and the city of Florence during the Italian Renaissance, might be cited as two outstanding examples of vitally interesting environments in which creativity flourished. Yet Greek tragedy and Florentine intrigue and violence give testimony to the fact that happiness, in the sense of bland contentment, did not characterize the people of those times.

Perhaps an important condition of a creative environment is that unhappiness should not be the smothering or crippling sort, but that if misfortune or unhappiness does occur, it should be of a kind that can be met, grappled with, transcended, or even capitalized on. Of course, there are many people who are both happy and creative—one certainly need not be unhappy to be interesting and to create.

Does the creative person seek in art something he lacks in the everyday world?

Although art serves many functions and is many things to many men, there is no doubt that to at least some creative individuals it represents a going-beyond, or a looking-behind, or a making-better of the world that presents itself to our ordinary senses. Imagination seizes upon possibilities which the real world may not as yet have brought to

actuality, and in that sense one can find in art what is lacking in everyday experience.

Do men and women differ in their innate capacity to make major contributions in creative fields?

If one surveys the history of science, mathematics, painting, musical composition, philosophy, the drama, and political and commercial enterprise, the answer would seem to be an emphatic yes. Men have made far more than 90 per cent of the important contributions in all of these fields of creative endeavor. It should be remembered, however, that woman's social role has traditionally restricted both her training and her activities in certain ways, with the result that her innate capacity may simply not have had a fair chance to develop. This social situation has been changing in the past fifty years, and it seems too soon to say whether woman's contribution to creative work is primarily innate or primarily determined socially. Certainly there are many stirrings, and there is much increased participation of women in activities traditionally restricted to men, so that we may be witnessing and participating in a major change in the role of women in creative work. Of course, women's place in nature is at the very heart of human creation, the making and carrying and fostering of new life. Men seem biologically adapted to aggression, restless seeking, external building, making laws and ruling, exploring, etc.; women, by virtue of their biologically given role as childbearers and their structural readiness for "including" are able to express directly in biological terms the kinds of capacities and needs that men express in the realm of thought and social action. It has often been said that for a man, his ideas (products, significant acts) are his children.

Why does it seem that creative people are often eccentric in their habits, dress, and manner?

People who think oddly often act and dress oddly as well, although this is by no means always true. As children, creative persons frequently realize that in some way they are different from those around them, and this inner difference in perception may readily give rise, intentionally or unintentionally, to outer differences. Sometimes, of course, the outer differences go along hand-in-glove with the inner. It is only when a person "puts on" differences, when he tries self-consciously to act or dress differently, that we begin to wonder whether the eccentricity is superficial and simply an act. In important move-

ments in art, there are usually a certain number of untalented hangers-on who talk, dress, and act like the real artists, and may even be accepted as real artists, but who actually do not create. Frequently, however, the genuine artist or creative scientist is really distinctive in bearing, dress, and manner; therefore it would be a mistake to interpret even consciously adopted eccentricities as pretentious. The unusual individual often feels isolated, and he may be pardoned for flying the flag of his individuality.

How is it that mentally disturbed persons can sometimes create works of merit and beauty?

The perception of beauty and truth, and the making of something beautiful and true, are certainly not the exclusive possessions of sanity. In fact, Plato said that unless a person has something of "divine madness" in his soul, he cannot create poetry. Often enough the mentally disturbed person is unusually sensitive, his very sensitivity being one of the reasons for his inability to adjust. Most of us erect walls against extreme feelings, unusual thoughts, moments of desolation or horror; sometimes the mentally ill person is one who either cannot or will not erect those walls, and as a result he has difficulty functioning in the way we call normal. Another result, however, may be that an unusual truth or an extreme beauty may be experienced vividly and then communicated through some artistic form. If we could have some of the advantages of mental agitation without the disabling disadvantages that usually accompany it, we might be persons of greater fulfillment. Creative geniuses sometimes seem to have just such an unusual combination of traits; they may be able to push sanity almost to the breaking point, but can usually swing back again, correct their perceptions, and make out of their transitory distress a social communication that they can give to the world and that the world can receive.

CRIME AND MENTAL DISORDERS

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Is criminal behavior a sign of mental illness?

To answer this question we must clarify what is meant by mental illness and also what is meant by criminal behavior. Mental illness, until recently, has been considered something one either had or did not have, like smallpox or pneumonia. But there is now an increasing recognition that there is no sharp line of distinction between mental health and mental illness and that a large majority of people may, at different times, show varying degrees of disturbance in thinking, feeling, and behavior. Disturbances in behavior are considered symptomatic of mental illness when they are accompanied by disturbances in thinking and feeling, and when they can be understood in terms of personality malfunctioning. Some experts believe, however, that deviant behavior need not always be accompanied by disturbances in thinking or feeling, but may occasionally arise out of a set of standards different from that of society.

When most people talk of criminal behavior, they usually mean offenses against the person, and the destruction or theft of property. Rarely do they think of people involved in syndicate crime, "white collar" crime, illegal business practices, and income tax violations. The prisons are full of the first group of offenders; the latter group is rarely found there.

As psychiatrists examine more and more of the offenders that do get into prisons, they find that almost all of them have mental and emotional aberrations of varying degree. These involve disturbances in emotional functioning, impaired relationships with people, tendencies to act rather than to think, disturbances in conscience (too strong or tyrannical as often as too weak), feelings of guilt, failure, and inadequacy covered over by an aggressive facade, as well as overtly delusional thinking. In some offenders these disturbances are relatively mild; in others, they are so severe, that they add up to serious mental

disturbance and what was called "mental illness" by the older standards.

Is the rate of crimes committed by persons with serious mental disorders increasing?

Yes. The apparent increase is due to the fact that many more offenders are being examined now than in the past and that standards of examination are improving. Currently, different examiners report incidence of serious mental disorder in prisoners ranging from under 10 per cent to well over 50 per cent. In general the more cursory the examination, the lower the proportion of serious mental disorder found. With examinations that meet high professional standards, with the use of psychological tests, and with laboratory facilities including X ray and E.E.G. (electroencephalogram), a much higher proportion of serious mental disorder has been reported.

But in interpreting these figures, we must remember that we are examining only the "unsuccessful" criminal. We rarely see the successful criminal. Various police estimates indicate that approximately one reported crime in five is cleared by an arrest; the proportion of arrests to crimes further decreases if one adds the unknown number of undetected crimes. It may be that the very high proportion of serious mental aberration we find is related not so much to the criminality of the offender but to his failure in crime.

Is the severity of a crime related to the degree of mental disorder?

To some extent. While individuals with major mental disturbances often are convicted of minor offenses, the more serious crimes against persons, like murder, are almost always committed by those with severe mental disorders.

Are the "career criminals" of the gangster-racketeer type mentally disturbed?

Not very many of these people get into prisons. Of those who do, some seem to be relatively "normal" in their mental functioning though they have a different set of moral values. Others, however, are very disturbed people under the surface. They have a distorted image of the world and their relationship to it, an emotional coldness, and a lack of concern for people—all of which would alert a psychiatrist even if no question of crime were involved.

What role does intelligence play in crime?

Crimes are committed by persons ranging in intelligence from mentally retarded to near genius. There is some tendency for persons of lower intelligence, particularly the mentally retarded, to be involved in crimes as the result of their poor judgment and high suggestibility, but the presence of a high degree of intelligence is no protection against being involved in crime. High intelligence can be swayed by emotional disturbance or unconscious motivation as easily as low.

What role does environment play in crime?

It plays an important role, both in the shaping of an individual's personality through the years and in its influence on the immediate situation. Behavior, whether criminal or noncriminal, results from an interaction between the individual, with his strengths, weaknesses, and specific vulnerabilities, and the environment with its opportunities, temptations, and demands.

A significant proportion of crime, particularly that arising in deteriorating urban areas, seems to be a combination of mild psychological disorder and rebellion against social conditions that are perceived to be intolerable.

Families living in such areas are often faced with ethnic and racial segregation, a relative lack of work opportunity and security, inadequately staffed and poorly financed school facilities, and fewer chances for satisfying relationships to others through church or other community groups. As a result, some parents find it difficult to maintain a home environment stable enough to promote the healthy development of children. Individuals growing up in such circumstances often experience the world as a place where it makes no sense to plan for the future, to depend on others, or to conform to society's standards.

These attitudes, when combined with the varying degrees of emotional disturbance that so often arise with such life experiences, create a vulnerability to pressures from associates that is often translated into antisocial behavior.

What factors might cause an individual to join in a criminal action with a group?

Assuming the group is one the individual likes and identifies with, factors such as these come into play: (1) contagion—the fact that other people like the proposed criminal action makes it sound better; (2) spread of guilt and responsibility—since it is someone else's idea, and

others participate in the crime, guilt is diminished by being shared and is, therefore, small enough to allow the individual to participate; and (3) feelings of inadequacy—the stronger the need of the individual to have the group like him, the less capable he is of resisting group pressure.

Is the individual who commits homicide very different from other types of offenders?

While individuals who commit homicide are generally found to be somewhat different from other offenders, the similarities to other offenders are often more striking than the differences. Whatever differences exist are differences in degree rather than in kind. Within the group itself, there is a tremendous variation, for there are many different types of homicide and many different kinds of killers. To the extent that they make up a single group, murderers can be understood by the same concepts and are seen to be driven by the same forces that drive all human beings. The important distinction is the disturbance in their psychological functioning that allowed the pressures, both internal and external, to be discharged as homicide.

Is it true that most persons have a latent capacity for murder?

Yes, if we change the word "murder" to "homicide." Murder, in our society, means killing someone premeditatedly, with "malice aforethought," and this requires a special constellation of psychological characteristics—emotional coldness, lack of concern for people, a high degree of self-love, etc.—which most of us fortunately do not possess. But there are circumstances in which each of us can be driven to kill. For example, to kill another human being when there is no other choice, in order to protect ourselves or our loved ones, is a capacity that all of us have, though it is rarely used. Because of variations in personality and in environmental situations, for example, the availability of a weapon, the conditions which might trigger an impulse to kill vary widely.

Are all sex offenders dangerous?

No. The community tends to lump all sex offenders into a homogeneous group, when in reality they make up a very heterogeneous group, consisting of persons with all types of emotional disorders, including some normal men who have had intercourse with physically well-developed girls under the age of sixteen. The community's attitude toward sex offenders is related, in part, to some deep-seated prejudices

about the expression of sexual impulses and, in part, to the mistaken assumption that these offenders all progress from minor crimes to more serious ones; for example, from voyeurism to exhibitionism, to molesting children, to violent rape and murder. While it is true that a small percentage of them are dangerous, the dangerous sexual offenders are more similar in psychic functioning and have more in common with dangerous offenders of other types—burglars and robbers, for example—than with other sexual offenders.

Is sex a factor in crime?

The female offender is generally a neglected topic of study, and much less is known about her than her male counterpart. It has been generally assumed that women commit fewer crimes than men, but careful studies have revealed that the real extent of female crime is much greater than the statistics indicate. Many crimes committed by women are never reported to the police; for example, shoplifting, thefts by maids and by prostitutes, and cases of fraud and blackmail where the victims fear publicity. Other crimes committed by women are simply tolerated and rarely prosecuted; for example, prostitution, homosexuality, and sexual offenses on children. In addition, all minor offenses by women tend to be handled unofficially by the police.

It seems clear that the biological differences of women, combined with the cultural attitude toward them, give them avenues for rebellion against society that are perhaps less obvious than men's. Women have the additional opportunity to satisfy their antisocial impulses by participating psychologically in the crimes of their male associates, even without being actual accomplices.

Are there basic psychological differences between a person who commits only one crime and a person who commits many crimes?

Very definitely. Demonstrating this difference is one of the most important contributions psychiatrists can make in working with offenders. Only on the basis of understanding the psychological differences between individuals who commit similar crimes can rational treatment programs be developed. For example, in some people, the crime may be a response to a traumatic experience, like the loss or threat of loss of a loved one. In others, the crime may be the result of a periodic buildup of great psychological tension which the offense itself discharges only temporarily, and which therefore can be expected to be repeated. In still others, the crime may be part of a well-ingrained rebellious and antisocial pattern.

Is it possible to predict who will become delinquent or criminal?

Indeed it is, and with a relatively high degree of accuracy. There are two main methods of prediction. One is statistical, in which certain criteria about the social background or the mental status of the individual are assembled in a table, given a weighted score, and the prediction made on the basis of the total score. The other is clinical, in which, on the basis of an evaluation of an individual's psychological functioning, one evaluates and predicts his future behavior. It is generally agreed that prediction tables work only as a screening device and that, where prediction is wanted in a particular case, clinical methods are more helpful.

What treatment is available for mental disturbances that frequently lead to crime, and how successful is it?

Treatment definitely is available for these psychological difficulties, but the rate of success is variable, and it depends on the exact constellation of psychological assets and liabilities in each case. The fact of any success is very significant, because it has been assumed by many that disorders in behavior cannot be successfully treated. One factor in any success, of course, is the skill and the experience of the therapist. A second is the necessity that treatment be conducted in a setting appropriate to the needs of the individual. Some individuals may be treated purely by psychotherapy, some need an equivalent of counseling and probation under the official pressure of the court, and others need treatment within an institution. (See *Correctional Institutions and Psychiatry*) A final factor involves the possibility of making some changes in the social and community forces that push in the direction of delinquency. To treat an individual successfully and then throw him back into the same conditions that led to his difficulty only invites relapse. This is particularly important in those cases of criminality where the social factors seem to be the more important.

What psychiatric research is being done in the field of crime prevention?

Some of the research involves sharpening the tools of diagnosis and prediction, so that psychiatrists can identify with increasing reliability those who are likely to be dangerous. But there is another kind of research going on, based on the assumption that delinquents are not evil out of choice, but are frightened and inadequate under the facade

of aggression. In an attempt to help potential delinquents align them-
selves with society, various workers have been going out into the field
with predelinquent and delinquent groups. These workers have con-
firmed the hypothesis that most of these individuals, though suspicious
and aggressive, feel basically inadequate and are hungry for social ac-
ceptance and opportunities for normal development. Also, there have
been studies in various communities throughout the country which
seem to indicate that simply giving potential delinquents the oppor-
tunity to talk to someone—not necessarily clinically trained—allows
them to get enough emotional relief so that the rate of delinquency
drops. But there are also some individuals who are quite disturbed
psychologically and need professional care, either inside or outside an
institution. If not given such care, these few often turn out to be the
leaders of the most destructive gangs.

Can crime ever be prevented? If so, how?

It is doubtful whether crime can ever be completely eliminated
from human society. There will probably always be some individuals
who cannot get along with society or who cannot accept its standards
and will have to fight it. The real question is whether it is possible to
decrease significantly the amount of crime we have today. There is no
question in the mind of this writer that not only is this possible, but
it is the only way the problem can be met. To try to reform criminals,
after they have become criminals, is a never-ending task.

The most important preventive device existing is for society not to
make criminals out of borderline cases. This involves the need for the
community to provide certain facilities for older adolescents, since they
represent the largest and most significant borderline group. There
should be opportunities for: (1) special vocational and other types of
schooling for those who will not go to college and who cannot do
academic work, (2) meaningful work for those who are ready for it, (3)
recreation geared to the needs of these individuals, (4) counseling and
treatment for those who need it.

In addition, for all age-groups there should be a kind, though firm,
and realistic attitude on the part of police and courts when these in-
dividuals get into trouble. The time of the first contact with the police,
or the first appearance in court, is often a crucial and deciding in-
fluence. If these individuals are treated as enemies, they become
enemies and remain so for a long, long time.

What can the ordinary citizen do to help prevent crime?

There are some little things that can be done in order to diminish the temptation of potential offenders. For example, always take the keys out of your car when you leave it; always lock your house when you are away; know your endorser before you cash a check. These may sound very simple, but well over 25 per cent of prisoners are incarcerated because ordinary citizens made it easier for them to commit their crimes.

In a broader sense, the ordinary citizen can help prevent crime by giving up his tendencies to a double moral standard, that is, by serving as an example to his children rather than telling them, in essence, "Do as I say, not as I do."

Beyond this, the ordinary citizen has to recognize that crime prevention requires trained people and costs money. He can encourage his legislature to spend the money required to develop programs in prevention. He can press for raises in salaries for police officers, for probation officers, and others in the field, since they are almost always underpaid. Well-trained people in these professions are worth their weight in gold. Without them no program, however sound it may be, can succeed.

Why is there so much confusion about the meaning of insanity in legal proceedings?

Today the term "insanity" is a legal term, even though it might once have had some medical meaning. In addition, it has several different legal definitions, each often confused with the other. For example, for the purpose of commitment to a mental hospital, insanity is defined as mental illness that makes a person "dangerous to himself and to others"; to invalidate a will, it is defined as mental illness, such that the person did not understand the nature and extent of his property and his relationship to his relatives. Therefore, a person can be sane (for the purpose of writing a will) and insane (committed to a mental hospital) at the same time.

In each of these examples, the standard on which the judgment is made is social or legal and not medical. For example, the psychiatrist can legitimately describe a person's disturbed thinking and behavior, but the question of where to draw the line between nuisance and real danger is a social one. Similarly the psychiatrist can describe how mental disorder may disturb a person's relationship to his relatives,

or his understanding about his property, but the question of how much disturbance in functioning invalidates a will requires applying the medical information to the legal or social standards. Psychiatrists can easily disagree about social standards even when they agree about the medical findings. Many legal and psychiatric experts strongly feel that psychiatrists should not be asked the social or legal questions, but only the medical ones, and that if psychiatrists are asked the social and legal questions, they should refuse to answer them. (See *Law and Psychiatry*)

What about insanity as a defense in a criminal trial? Why do we so often see a "battle of experts"?

The use of insanity as a defense is related to the concept that, although willful misbehavior is to be punished, misbehavior in which the "evil intent" is absent, because of mental disease, is not to be punished. For the last 120 years the English-speaking world has been using the M'Naghten Rule—familiarly called the "right and wrong test"—to determine whether a defendant was sane or insane. The main difficulty with this test was that it limited itself to one consideration, the defendant's knowledge about what he was doing, and it excluded every other symptom. With such a narrow test, narrowly interpreted as to require "all or none" answers, almost all mentally ill people would have to be considered sane, since only a "drooling idiot" can be said not to know what he is doing. Psychiatrists testifying under this rule have been in the position of describing the color gray as either black or white, neither of which is accurate.

The psychiatrist, in testifying about insanity in a criminal case, really addresses himself to a nonmedical question, namely, should the defendant be punished. For practical purposes, this means should he or she be executed, since the issue is raised mainly in capital cases. The psychiatrist's technical knowledge gives him no special capacity to judge which human beings should be executed and which should not. This the jury has to decide. The psychiatrist's expertness is in the area of what is wrong with a person's mental functioning and what can be done about it. The fact that mental disturbances cannot be described in "all or none" terms is the jury's problem; when the psychiatrist allows himself to answer in such terms, he usurps the jury's function.

Complicating the problem is the fact that when horrible crimes have

been committed, the law often just goes through a ritual of getting psychiatric opinion and doesn't face the issue of whether the accused is mentally ill or not. In 1930 Justice Benjamin Cardozo summed up the situation in *What Medicine Can Do For Law* by stating: "If insanity is not to be a defense, let us say so frankly and even brutally, but let us not mock ourselves with a definition that palters with reality. Such a method is neither good morals, nor good science, nor good law."

The fault, however, is not entirely the law's. Even though psychiatrists can accurately describe disturbances in behavior, thinking, and feeling in criminals, many of them share the common beliefs of the community in which they live. Some psychiatrists feel that mentally disturbed criminals should not "escape" punishment; others feel differently. Just as there were times when some physicians testified that some individuals were witches and should be burnt at the stake, and others disagreed, the same process can be seen today. Psychiatrists, therefore, when asked a social question, framed in the "all or none" language of the M'Naghten Rule, often respond in terms of their social opinion. Psychiatrists can easily disagree about social standards even when they agree about the medical findings.

The situation, however, has been shifting considerably in recent years, and new rules of criminal responsibility are appearing. These enable a psychiatrist to testify in such a way that his knowledge becomes meaningful to the court and that needless differences of opinion disappear. The most significant of these modifications have been: (1) the Durham decision, which states that the accused is not punishable if the alleged criminal act was a "product of mental disease or defect"; and (2) the Currens decision, which states that the accused is not punishable if, as a result of mental disease or defect, he "lacked substantial capacity to conform his conduct to the requirements of the law which he is alleged to have violated."

What is the purpose of capital punishment? What are the various views held by mental health authorities, penologists, and others in the use of capital punishment? What effect does the threat of the death penalty have?

The existence of capital punishment is the symbolic remnant of the old retributive attitude to the criminal, but it is slowly dying. Year by year fewer people are executed. In 1961, in contrast to the 24,610 known cases of homicide and rape, there were 42 executions throughout the entire United States.

Two main arguments are most frequently advanced for the retention of the death penalty. One is that the threat of its infliction deters people from committing capital offenses, and the second is that the execution of criminals protects society from them. Behind these arguments, and their variations, is the idea of retribution—the feeling that the criminal ought to die because he has done something terrible—though it is rarely advanced openly any more.

Most professional people involved with questions of crime are strongly opposed to the death penalty. Almost all members of the mental health professions oppose the death penalty, since they feel that it is based on the notion, long discarded by them, that man is entirely rational in his behavior, that he always weighs the consequences of his acts, and is therefore guided in his behavior by the threat of a death sentence.

The majority of penologists feel that the death penalty is unsound, because it represents the antithesis of the new penology they are striving to develop. They feel that it brutalizes the entire administration of correctional work. Most religious leaders oppose capital punishment on moral grounds. Many jurists feel that the continued existence of the death penalty complicates the administration of criminal justice, and adds to its cost. It increases the number of trials and tends to make them more sensational; it results in innumerable appeals. Though rarely invoked, it blocks reform in the retributive concept of the criminal law.

There are, however, a significant number of judges who are in favor of the death penalty, together with most prosecuting attorneys and police officials. Their argument is "practical." They feel that the death penalty is necessary in order to protect police officers and prison guards. This writer feels that the most important reason these groups are in favor of the death penalty is that, because they are close to the "firing line" in working with offenders, they almost never see them as human beings capable of being rehabilitated, but only as dangerous, even inhuman, enemies. With no training in the behavioral sciences, they see no alternative to the execution of criminals they feel are dangerous. All they see is the endless mass of offenders they must fight, and it is a discouraging picture for them.

The most serious effect of the retention of capital punishment is that it lulls the community into thinking the problem of the criminal has been solved and thereby prevents it from really finding solutions.

Do psychiatrists oppose all punishment in the law?

Psychiatrists are not opposed to punishment as a concept in the law, but they are opposed to its automatic, nonrational, and exclusive use as a method of dealing with offenders. It makes no sense to fit the punishment to the crime; it needs to be fitted to the offender. While the concept of punishment is a necessary part of the law, it needs to be recognized that the desire to find love, approval, and respect among relatives, friends, and business associates, rather than the fear of punishment, is what keeps most people from violating the law. For those who seem not to care about society's opinion and for whom the threat of punishment is not a deterring factor, measures other than severe punishment are needed.

In the law itself there is an increasing movement away from rigid retributive justice. We see it in the development of indeterminate sentences, in laws designed for treatment rather than punishment of sexual offenders and drug addicts, in the establishment of diagnostic centers within correctional systems, and the proposed "model sentencing acts" of the National Council on Crime and Delinquency. (See *Correctional Institutions and Psychiatry*)

Why does the problem of crime seem to be getting worse rather than better?

Society is not really committed to the goals of rehabilitation and prevention, and is, therefore, in the position of doing too little, too late. In spite of very real problems about resolving valid competing demands for the limited funds, the major difficulty is the public's attitude. The community seems to be growing more, rather than less, hostile to the offender as it sees itself seemingly overwhelmed with delinquency and crime. Not only is there a growing indifference to the convicted offender, but we even see a slipping back in some states to the use of discarded practices—the whipping post and the reinstitution of capital punishment. We live in an era which has tolerated so much human destruction—the destruction of entire cities by atom bombs, the murder of millions in concentration camps, the slaughter of civilians in Algeria, Hungary, Berlin—and which is now threatened by thermonuclear destruction, that we perhaps cannot help being less sensitive to the plight of the helpless and the social outcast. Welfare problems, particularly involving the deviant, become at best, annoying things to

be turned over to public agencies and forgotten, and at worst, situations to be handled with intolerance and hostility. Eventually the community will realize that it is too expensive to ignore and mistreat the offender, and thereby fail to prevent crime. But the situation may have to get worse before it gets better.

CULTURE AND PERSONALITY

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Is there a relationship between culture and personality?

Culture is the term we use to describe all of the learned behavior of people reared in the same society or living in a given society long enough to share its way of life. Culture also includes all the objects that have been made or imported by present or previous generations—houses, churches, temples, forts, books, pictures, etc. Personality is a term that describes the behavior of individuals—behavior based upon their hereditary qualities and their life experiences within the culture or cultures in which they are reared and live out their lives.

An important aspect of each individual's personality is the character that he or she shares with other members of their society. Although each individual accepts, rejects, and reinterprets cultural experience in a unique way, the regularities in the behavior of those reared in the same culture are very great and easy to identify: they speak the same language, stand and sit, work and sleep, welcome or fear strangers, court and marry, save and spend, and bury their dead in culturally regular ways. The universal human types of behavior—the capacity for love and hate, for fear and bravery, and for shame and pride and guilt—are developed differently in different cultures. Not only will the same act be judged very differently, but the motives for a given act will vary between cultures. What is a coward's deed in one culture may be an act of prudence in another; an insult in one culture may be seen as a casual joke in another.

Identical twins separated at birth and reared in different cultures best illustrate the significance of cultural differences. If one twin stays in his native country, France, and the other is reared in Germany, they will grow up speaking different languages and responding to different appeals; they will be worried and guilty about different things, and have different aspirations. These differences will be apparent at the deepest layers of their character, as well as in more superficial matters

like different tastes in food and drink and in their expressed loyalty to one government rather than another. The similarities based upon their common heredity will remain, but their characters will be different. This would also be so if one twin had been taken to some faraway, primitive people, like the Eskimos. He would grow up speaking Eskimo, laughing at Eskimo jokes, and be ready to choose an Eskimo girl as the most desirable wife. Only when such adoptions are made by people who look very different because they belong to different racial stock, may the difference in physique give rise to treatment different from that which the adoptive parents would give their own children. Thus, members of minority groups who differ in physical appearance from the majority—as Negro-Americans and Asian-Americans do in the United States—not only share the general cultural character of all Americans, but will also as a group show certain regularities because they are treated differently and treat each other differently than the majority group. In the same way in large and complex societies members of different social classes, or of different regions, or those who practice special occupations—farmers, fishermen, lawyers, nuns—may also have a character that shows certain similarities and that differs from the character of the majority.

What is the study of culture and personality?

The study of culture and personality is a field of research in which the knowledge we have about the development of personality—in infancy, in childhood, in adolescence, and in maturity—is brought to bear on the members of a particular society, through the study of identified individuals. The study may be pursued in order to find out what all human beings have in common, in spite of the great historical differences between Eskimo and Egyptian, South Sea Islander and modern Russian. Only by systematically studying the development of personality in many different kinds of societies can we separate that which is learned, but need not be learned, from behavior that is universal in the human species. For example, all children will learn to walk, but whether they creep or crawl, whether they squat and stand or stand and squat, whether they learn to skip, to dance, to high jump, or to parachute will depend on the culture. All children need care from older and more experienced persons, but which relatives—mother, grandmother, father, older sister, nurse—give that care will vary with the culture. So also will the degree of disturbance that arises in a child's life if he is orphaned or separated from a parent for a long time.

Combined with the search for common human behaviors, the study of culture and personality attempts to find out the significant differences —in the way individuals learn to think, feel, and act—which may be attributed to culture. By identifying the ways in which different kinds of character develop within particular cultures, we then have information to guide us when we wish to make, or prevent, changes in any contemporary societies, such as changes in the way families live—parents and children only or with grandparents—in the age at which children go to school, types of punishment permitted by law, age of marriage, etc.

What is the history of the study of culture and personality?

This study grew out of an appreciation that if human behavior was learned, and if cultures differed, and if the experiences of children would therefore differ profoundly, then there would be systematic differences among members of different cultures.

It grew out of the growing understanding of anthropologists that cultural behavior has to be learned by each generation, and of psychologists, biologists, and psychoanalysts that the way in which a child is reared and the experiences he encounters at each developmental stage will be significant in his personality. It is a branch of human sciences that originated in the 1920's, mainly in the United States, but in response to many types of studies that had been pursued in Europe and Great Britain.

Who were the people instrumental in this study?

The initial impetus was given by Lawrence K. Frank, who as an executive of the Laura Spelman Rockefeller Memorial, was able to bring groups of people together from different disciplines, set up long-term studies of children in our own society, and identify the usefulness for culture and personality studies of methods that were being developed in the different related human sciences—life histories, projective tests, studies of the ways in which certain character formations accompanied certain diseases, etc. Among the anthropologists instrumental in the study of culture and personality were: Ruth Benedict, Edward Sapir, Margaret Mead, Ruth Bunzel, C. G. Seligman, Gregory Bateson, A. Irving Hallowell, Geoffrey Gorer, Ernest Beaglehole; among psychoanalysts: Géza Róheim, Erik H. Erikson, Harry Stack Sullivan, James L. Plant, and Abram Kardiner; among psychologists:

Bruno Klopfer, Otto Klineberg, Henry A. Murray; among sociologists: John Dollard, William F. Ogburn.

Which professional groups are concerned with this study?

Such groups include: (1) cultural anthropologists, that is, those anthropologists who emphasize the study of the cultural behavior of living groups of people, rather than the study of physical type, language, or archeological remains; (2) psychoanalysts who are interested in the way culture shapes the individual's ability to handle his hereditary drives; (3) clinical psychologists who are interested in instruments that can be used to assess personality style and to identify strengths and weaknesses: instruments such as projective tests—the Rorschach inkblot test, the Murray Thematic Apperception Test, experimental situations in which individuals are asked to solve problems or perform tasks under stress, interpretation of works of art, etc.; (4) sociologists who are concerned with norms, roles, and social class; and (5) child development workers who are concerned with differences in developmental styles.

What are the various approaches to the study of culture and personality?

The various approaches are:

1) the anthropological approach, based on the intensive study of small, usually preliterate groups of people, where the anthropologist can study the whole culture, know the relationship of each person in the group to each other, follow the methods of child rearing, the religious rituals, the methods of conducting human relations, in detail, day by day, and so describe the regularities in the behavior of the individuals born within that society;

2) the sociological approach, which uses a sample of individuals within a larger society, and by a combination of statistical methods, interviews, questionnaires, available data on crime, delinquency, absenteeism, suicide, etc., attempts to establish correlations between institutions in the society, roles played by individuals as fathers, employers, taxpayers, etc., and population characteristics such as proportion of people of different ages and sexes so as to show that certain attitudes, behaviors, and beliefs occur with certain frequencies within a given society;

3) the psychological approach, which relies upon the use of certain instruments: projective tests like the Rorschach inkblot test and attitude scales; picture interpretation; free drawing; experimental situa-

tions in which the individuals are artificially put under strain; from which, for example, coherent pictures of the personality of Algonkian Indians or overseas Chinese, or Spanish-Americans in the United States Southwest can be constructed, which then can be compared with each other in such respects as amount of hostility, ways of seeing the world, etc.;

4) the psychoanalytic approach, in which selected individuals are actually given a psychoanalytic type of prolonged interviewing, or in which psychoanalytic interpretations based upon psychoanalysis of individuals in Western cultures are used on materials such as jokes, comic strips, movies, literature, and group rituals like burials or fraternity initiations to construct hypotheses about the character they would find if they could psychoanalyze members of the culture being studied. Particular emphasis is laid upon the way in which the child's emotional relationships to parents, brothers and sisters, and his own body develop in different cultures;

5) the constitutional approach, in which students of human physique and the significance of the somatotype—the proportions of the body—for personality, follow the distribution of different somatotypes in different societies or parts of a society and the different roles assigned to them, when, for example, in a given society, a masculine type woman is preferred to a more feminine type, or both sexes are valued when they show a weak development of secondary sex characters such as muscles, breasts, etc., or when there is an aristocratic type demanded of the nobility, etc. This approach is the least developed of the five. (See *Constitutional Variation and Mental Health*)

A full study of culture and personality needs to take account of all these approaches and use all that are suitable in a given situation.

What conclusions have been reached from the study of culture and personality?

First, it has been shown that behavior, even that manifested by a single individual in a society, is patterned by the culture: thus the artist, the musician, the criminal, rare though he may be, can be identified as a member of his culture. The forms his paintings or his crimes take are culturally determined. The individual is born with greater or lesser capacities for certain types of behavior, but whether these behavior patterns will appear will depend upon the culture, and on his exact place within the society. For example, the same degree of mathematical superiority may result in such a sense of distance from other

people that one may become a seer in one society, withdrawn and emotionally disturbed in another, a leading physicist in a modern country.

Second, the study of culture and personality has reinforced the anthropologists' assumption that there are no racial differences in capacity for feeling, thought, or action, in sensitivity, in musical ability, in capacity for integrity or growth, but that all such apparent racial differences are due to the different cultural conditions under which individuals, and sometimes whole races, have been reared and have lived. There are, however, significant innate differences among individuals in all races, which will determine how individuals learn their culture and how much influence they have in changing it; but no racial differences have been found.

Third, the extent to which comparable behavior can be found in individuals who grow up in different cultural conditions reinforces the belief that there are behavioral characteristics that are both uniquely human and characteristic of the whole human race, some of them very specific, like the way an infant learns to smile, and some very general, like man's attempt to understand the universe in which he lives.

How are these conclusions applicable to the individual?

These conclusions are applicable in many ways. Until we know what culture an individual comes from, we cannot tell whether he is expressing extreme fright or ecstasy, whether he is tired or ill, whether he is insulted or shy, whether he is saying yes or no (some people shake their heads to say yes, and nod to say no). Teacher, physician, hotel clerk, or even a casual passerby-at an accident, must know whether the pupil, patient, guest, or casualty, is a member of his own culture or a stranger, before any judgment can be made. In the same way, no one fully knows himself who does not understand what parts of his personality and his behavior are his because, for example, he is an American, who was born, reared, fed, and taught, in particular ways that now govern his habits, his responses to differences, and his ability to grow and to change.

Which groups play a great part in influencing the personality of the individual throughout his life?

The individual's personality develops in communication with other human beings. First, those who succor the infant—mother, grandmother, aunt, sister, father, brother, nurse; then, increasingly, playmates

and age mates—in the family, in the neighborhood, and at school. During adolescence the importance of the peer group is supplemented by an increasing importance of adults who are not members of the immediate family—teachers, heroes alive or dead, characters in the movies, in fiction, and in the news. During courtship and marriage, the personalities of the proposed mate and of the future parents-in-law may be very important, as are the personalities of employers, supervisors, and work companions.

As one matures, the personalities of one's children and of those whom one supervises, employs, and teaches become more and more important in shaping the way that increasing years and experiences are met. In the early years of culture and personality work there was too much emphasis on the effect of parents on children at the expense of exploring the tremendous effect that children have on parents, grandchildren on grandparents, and pupils on teachers.

Has the study of culture and personality found scientific support for attributing certain patterns of personality or behavior to certain groups?

Culture and personality is a branch of the human sciences. As in all young sciences, there have been tremendous controversies over each innovation in theory or in method. The acceptability of any specific findings depends upon the acceptance of the theoretical assumptions on which they are based, and the methods that are used. For example, some psychologists will claim that because the Rorschach test has never been validated in our own culture, as it has never been shown to correlate with other measures of personality, such as success in the armed forces or ability to pass examinations, the findings based upon its use in other cultures are not valid. Other critics emphasize the importance of large, random, or specially structured samples and distrust findings based on the study of small tribes. Others distrust reports made by single investigators (much of the work on isolated and primitive people has been done by one or at most two investigators). However, modern methods of recording by the use of photography, movie film, and tape make it possible to overcome most of the objections that have been raised against the *methods* of the studies, because events that occurred only once can now be analyzed many times, by different methods and by different scientists.

The principal criticisms come from those who wish to work with

large numbers of cases and very few variables, who wish to translate their results into statistical terms at once, and who distrust both the human investigator himself and the tools now available to make his observations permanent.

What is the relationship between cultural factors and mental disorders?

This is a subject that has interested many investigators but is far from resolved. The obstacles are many. Mental disorders are differently classified and named in different countries; diagnosis is difficult unless the diagnosing psychiatrist speaks the language and knows the culture. Many small groups where the culture has been studied intensively are so small that only a very few mentally disordered persons will be found.

Is the degree of mental health or mental illness the same throughout all cultures? If not, why?

At present it may be said that psychotic disorders are found in all known societies and that, although some of the symptoms may differ and the treatment will vary (the individual may be treated as accursed, as chosen by the gods, or as a shameful event in the family), the basic psychodynamics appear to be very similar. However, the proportions in which various psychotic mechanisms appear—extreme depression, extreme excitement, self-accusations of sin, ideas of persecution by others, delusions of hearing voices or seeing visions—will differ from one society to another. In complex societies a larger number of psychotics may be found in certain areas to which they have been attracted, like the slum areas of large cities, etc., or certain groups to which they have drifted, like casual laborers, extreme religious cults, etc.

There is a far greater difference between societies in the expression of neuroses, the cases where individuals have learned to use inappropriate ways of solving their life problems, and in the social symptoms of such disorders: in the extent of suicide, homicide, alcoholism, drug addiction, vagrancy, and crime, on the one hand, and, on the other, in the amount of recourse to religious rituals, pilgrimages, membership in protective groups (e.g., Alcoholics Anonymous), vows (e.g., total abstinence), isolation of deviant individuals in special colonies or occupations, and resort to psychotherapists—shamans, healers, physicians, and, today, psychiatrists and mental health practitioners.

Is the rate of mental illness the same throughout all cultures? If not, why?

In periods of rapid change, as people move from country to city, from farm to factory, from a peasant country to an industrialized country, or from primitive tribe to a modern society, new forms of mental disorder may be expected to appear as the old familiar protections are withdrawn. Some old forms, rooted in the isolation and loneliness of the country or in the inescapable net of one set of relatives and neighbors who early in life form an opinion from which an individual has little chance to escape, may disappear when there is more freedom for individuals to begin life over again in new and more congenial surroundings.

Societies differ also in the relationship between the expectations that they arouse in children and young people: in those societies where high expectations are aroused but not fulfilled, there may be new forms of mental illness. The present high rate of vaguely defined mental illnesses in new American suburbs is one example. Another related type of illness may appear when individuals reared in expectations of quite humble roles in colonial countries have, through the independence of their countries, positions of great responsibility thrust upon them. (See *Social Change and Mental Health*)

Comparative culture and personality research leads to the conclusion that while psychosis may, with sufficiently good knowledge of the language and culture, be diagnosed across cultural lines, other forms of mental disorder and malfunctioning are exceedingly complex and cannot be identified by any set of universally valid criteria. This is particularly so when it is realized that mental health has now been defined as *optimum*, which is explained in the following quotation from *Mental Health in International Perspective*, a publication of the World Federation for Mental Health:

> "Mental Health will, therefore, necessarily always refer to a state of functioning which is relative to a given situation of a particular individual. Thus, the criteria of mental health will differ for a three-year-old and a six-year-old, and again for an adolescent of sixteen, and so will those for a boy and for a girl respectively. They will also vary according to social circumstances, innate capacities, and the culture in which the individual is reared, and that within which he lives. No definition is acceptable that does not take into full account the importance to the individual of his environmental context.
> "The term, 'positive mental health,' is inadvisable, implying as it

does the possibility of negative mental health. The phrase, *optimum mental health,* is preferred, and refers not to an absolute or ideal state, but to the best possible in the particular existing circumstances. It is realized, however, that ideals such as 'perfect balance of intellectual, affective and moral faculties, a complete integration at the center of moral and physical well-being'—as it was phrased by one member—may well provide inspiration for work in mental health in some particular cultural settings." (See *Optimum Mental Health*)

How does the study of culture and personality contribute to general research in human behavior?

It provides an essential corrective to the bias introduced by studying behavior within one culture. Only a knowledge of the way in which human impulses are educated and express themselves in other cultures makes it possible to interpret research results in our own culture. For example, experiments in response to success and failure, reward and punishment made within one culture would come to completely fallacious conclusions, inasmuch as some peoples react to failure with renewed efforts, whereas others will despair. Competition, which is such an easy motive to invoke in our own culture, plays a far smaller part in many other cultures. Fear itself may be differently experienced. Memory can be culturally patterned so that the people of one tribe will be able to repeat a new narrative verbatim, and those of the next tribe might be quite unable to do so because of the way they have been reared. Recent experiments in the United States on the effects of depriving experimental subjects of all stimuli—of sight or sound or touch—need to be reviewed in the light of the behavior of Indian mystics who are able to suspend all bodily functions for many hours without the same effects. No generalization about human behavior is valid without cross-cultural testing. (See *Sensory Isolation*)

Based on current studies, what might be predicted about the relationship between culture and personality in the near future?

Two contemporary conditions may be expected to introduce new complexities into the problem of personality and culture. The first is very rapid and uneven cultural change. Where a whole group of people undergo a change together, voluntarily, the personalities of the individuals, after the change has occurred, show a systematic relationship to their old personalities. They may even speak a different language, engage in a new occupation in a new country and yet undergo relatively

little personality change. This was true, for example, of colonies of European immigrants who settled in the United States and Canada in villages and in rural areas. However, where the continuity of the group and the relationship between parents and children is broken, through industrialization or migration, an uneven or almost random quality is introduced into the way in which different personalities will respond to the change. It becomes less possible to predict the behavior of individuals from knowledge of the cultural regularities in their characters. More knowledge of each individual is required before plans can be made by, for example, educators, social workers, or employers.

One of the problems in the United States will be whether to carry the largely American-born grandparental generation along on the stream of rapid change so that there will be more continuity and therefore more predictability of behavior.

At present our adolescents are increasingly responding to the mass media rather than to behavior models provided by the adults in their own families and communities. Although this provides a very shallow set of models, it makes rapid change possible; but the ability to withstand hardship or endure protracted trial and effort does not seem to develop as well under these conditions.

A second factor is that of cultural complexity. The more complex a society is, in terms of class, occupation, region, religion, etc., the more complicated are the relationships of each personality to the culture of the whole society. If the differences between subgroups are very clear and well known, marked by differences in clothing and manners, the relationships, although rich and variegated, are not as complicated as in a society like ours, where each individual can, theoretically, make friends with or marry a person from among millions of other individuals of very different background. In India, for example, children grew up as life members of their own caste, and learned about the behavior of other castes, which would never under any circumstances be their own behavior. In the United States today, except where archaic caste barriers exist among Negroes or Asians and white people, it is conceivable that any two persons of the same age, sex, and education might change places in the society. This extreme flexibility and ambiguity means a type of personality in Americans, *as Americans,* that can only be described in much more general terms than would have been possible for India, or Old Russia.

As different parts of the world become more open to each other, people born in one part of the world may increasingly expect to live

and work in another. New methods of rapidly learning those things about a culture that are normally learned in childhood are being developed. The individual who learns a new culture in adulthood has a different relationship to this learning than does the individual who lives in the same culture all his life or who moves with a group of relatives and neighbors to the city or to a new country. We may expect a new kind of cosmopolitan man to emerge, with new mechanisms for preserving a sense of identity and for integrating the different periods of life or the different segments of life that are spent in close contact with cultures other than his culture of origin.

DEATH

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What is death?

Otto E. Guttentag of the University of California School of Medicine indicates that current biological literature offers no systematic discussion of death. Many textbooks in physiology do not even list the word. Present lack of a clear understanding of the term "death" points to a gap in medical knowledge. The definition of death as it applies to multicellular organisms is necessarily arbitrary. Death is usually considered as the state of the body when all signs of life are absent; notably, the heartbeat, respiration, and movement. Death of the organism must be separated from the death of organs or cells. The organism is dead when all signs of life are absent and when no known means can restore these signs. Organs and cells are capable of functioning for varying periods after death of the organism, particularly if provided with oxygen and other needed substances by artificial means. Some cells, if kept under proper conditions, are potentially immortal.

What is the body's last physiological function before death? Heartbeat? Nerve impulses?

According to Victor E. Hall of the University of California at Los Angeles (U.C.L.A.) School of Medicine, the body's last physiological function before death depends on the cause of death. Electrocution, for example, stops the heart almost instantly although respiration and some reflexes can persist for several seconds. A blow on the back of the head can stop respiration, yet the heart can continue to beat for a minute or so afterward. Some nerve impulses can also function for a short period after the heart stops.

When a person's heart and breathing stop for many minutes and then are revived, has the person been dead?

Biologically, the answer is clear. He has not been dead. As a result of recent work by Professor V. A. Negovskii of Soviet Russia, a further

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distinction is now being made between *clinical* death and *biological* death, particularly with regard to sudden death occurring in violent accidents, childbirth, or in heart attacks. By clinical death is implied the final, but in many cases still reversible, stage of dying. At this time "cardiac activity and respiration have ceased; consciousness has usually been lost before this stage, but life at some low is still present—an isolated, primitive life of individual tissues and organs." Clinical death is the interval of time during which the higher divisions of the brain may survive after cessation of cardiac activity and respiration. This is ordinarily from five to eight minutes. Once it has passed, biological death and gradual decompensation of the body occur.

How can muscular reflex occur after death?

True reflexes almost always disappear by the time breathing stops. However, it is known that an electrical shock applied to a motor nerve or a muscle can cause the muscle to contract. This merely means that functional capacity remains in the peripheral nerves and muscles after the organism as a whole is dead.

Why should people be interested in death?

Almost two million people die in the United States every year. The democracy of death will eventually include us all. Even before its actual arrival, it is an absent presence. Some investigators also hold that fear of death is a universal reaction and that no one is free from it. The individuality of each of us gathers full meaning only in realizing that we must die. And it is in this same encounter with the idea of death that each of us discovers his hunger for immortality.

To deny or ignore oncoming death is to distort life's pattern. Death is a constitutive part, rather than the mere end, of life. It is another life experience. Only by integrating the concept of death into his life can the individual completely understand himself.

What ideas do people have about death?

Death can mean different things to different people. Its specific meaning depends on the nature and fortunes of a person's development and his cultural setting. To many, death represents a teacher of transcendental truths incomprehensible during life. For others, death is a friend who brings an end to pain through peaceful sleep. Still others

visualize it as an adventure—a great, new, oncoming experience. And, there are those who see it as the great destroyer who is to be fought to the bitter end. This view is beautifully described by Dylan Thomas, the Welsh poet: "Do not go gentle into that good night, old age should burn and rave at close of day; rage, rage against the dying of the light."

In addition, Walter Bromberg and Paul Schilder have indicated that, on an unconscious level, death may be seen as a means of vengeance, to force others to give more affection to us than they are otherwise willing to give us in life; as an escape from an unbearable situation to a new life without any of the difficulties of our present life; as a means of punishment and atonement, etc. Research by this writer shows that ideas of "failure" and "punishment" dominate the mentally ill patient's attitudes toward death, whereas thoughts of the "unknown" and "loneliness" are paramount in both physically ill patients and normal subjects. To sum up: "Death is terrible to Cicero, desirable to Cato, and indifferent to Socrates."

What influences people's ideas about death?

Attitudes toward death are the result of many interweaving factors. Some of the more significant variables seem to be the age of the person, religious orientation, psychological maturity, and level of threat. For example, it is apparent that the thought of death may mean one thing at the age of twenty, another thing at the age of forty, and something quite different at the age of sixty. Or, consider the aspect of the temporal nearness or distance of personal death. It is wholly conceivable that a person's perception of the world and attitudes about death might not be quite the same tomorrow as they are today, if meanwhile he were informed that he had a spreading cancer. Likewise, knowing that you are suffering from a disease that will lead to death, and remaining in your everyday environment with its regular duties and problems, is quite unlike being immobilized and awaiting death in a hospital bed.

Clinical observation prompts the reflection that knowledge of the "external" degree of threat alone seems to be an insufficient base on which to predict with any certainty how a person will react to it. Information that one is to die in the near future does not necessarily constitute an extreme stress situation for specific individuals. The type or kind of person one is may sometimes be more important than the threat of death itself in determining the individual's reaction.

How might a person's feelings about death influence his life?

Individual differences play a prominent role here too. Our life receives one of its principal directions, if not its main one, from what death means to us. The kind of immortality we seek has a major impact on the kind of life we lead, whether the immortality be biological (children), social (work accomplishments that testify to our existence and live on in the thoughts of the living), or transcendental (belief that this life is but the precondition for the "true" life yet to come).

There is, of course, the *carpe diem* (seize the day) outlook of the Roman poet, Horace, which highlights personal pleasures and gratifications. His philosophy implies that since this life is the only one we have, let's "live it up." Others with a similar philosophic view feel that if we *do* have only this one chance at living, then life must be utilized to its utmost to give it full value and meaning. Obviously, there is also the religious outlook that guides us to live in such a manner as to be judged favorably in the hereafter. Full appreciation is often not given to how the thought of death can serve man positively, as a galvanizing force pushing him forward toward creativity and accomplishment.

Can a person learn to accept the significance and inevitability of his death?

Yes, most of us do this sooner or later on one level or another. Intellectual acceptance of the idea usually comes much earlier and more easily than the emotional grasp of its meaning. Human maturity, William E. Hocking has noted, brings along with it a recognition of limit, which is a notable advance in self-knowledge. In a certain sense, the willingness to die appears as a necessary condition of life. We are not altogether free in any deed as long as we are commanded by an inescapable will to live. In this context, the everyday risks of living, e.g., driving downtown, taking an airplane trip, losing one's guard in sleep, become almost forms of extravagant folly. Life is not genuinely our own until we can renounce it.

Does an individual's acceptance of inevitable death increase with age?

The answer is usually "yes," but again this depends on the specific individual. Most of us, in early youth, do not fully accept the inevitability of our own death. Death is something that happens to someone else. Only as we grow older and catch glimpses of death's face because

of personal illness, a war experience, or death of a parent, does respect for, and greater acceptance of, death come to the foreground. This is further intensified when we see close friends and persons of our own generation die. Many older people receive the thought of death more readily than they did in their younger years because "you've lived your life," "you accept and are resigned to it," "you've least to live for." Others, however, may become more anxious as they grow older, because they see death as bringing them nearer to a judgment that may demand punishment for the avoidable evils they have done. Still others perceive death as stamping the final seal of "failure" on them with no further chance to accomplish things they had hoped to do. Generally, those people who feel that they have lived meaningful and full lives, adjust to, and accept the inevitability of, death much better than those who feel that life has cheated them.

At what age are people most afraid of death? Least afraid?

Data from this writer's research reveal that normal subjects, over-all, select the decade of the forties as the period when death is most feared. This is because "you have a lot to live for then, and most to lose" and "you now realize that it can happen to you." This is followed by the seventies-and-over period because by then death is fairly imminent. This is in contrast to emotionally disturbed patients who, for the most part, choose childhood as the span when they most feared death. The major reasons are because "you're scared," "don't know what it is," and "can't handle the idea." Others state that fears engendered by religious catechism and loss of a parent are responsible. This early chronological placing of fear of death by mentally ill patients may mirror retrospective trickery, native below-par coping abilities, or exposure to more frequent adverse life situations. Further exploration is required. It is relevant to note that recent studies disclose that parental bereavement rates are higher in the early years of life for psychoneurotic male veterans than for the general population.

With reference to the age when people are least afraid of death—a majority of all groups picked the adolescent years between thirteen and twenty. The reasons given were "because life is all ahead of you yet," "it doesn't enter your mind much," "life is roaring." This, naturally, does not mean that adolescents do not think about death or that it cannot become a matter of concern for some. Most of us, during our teens, usually repress or mute thoughts of death. Childhood was the

second most chosen interval because "you don't know what death really means," "life is carefree," and "all is in front of you." Interestingly, childhood was named as the least worrisome time pertaining to death even by some of the mentally ill patients. Again, one must keep in mind that childhood also can be a period of great stress concerning ideas about death. Most of us, here too, tend to repress our anxieties or to bind them in neurotic symptoms when they become too unmanageable.

Under what conditions do people normally become conscious of thoughts dealing with death?

This writer's findings indicate that people ordinarily become conscious of thoughts about death and dying in the following major situations: (1) when they personally become seriously ill, (2) when someone in their immediate family becomes seriously ill or dies, (3) when friends develop a serious illness or die, (4) when they join the armed forces or are involved in a war situation, (5) when they are personally involved in an accident of some consequence, (6) when disastrous public accidents are reported in the newspapers or over radio or television.

How would people spend their time if they knew they had only six months to live?

This writer discovered no major differences between healthy persons and seriously ill patients who knew death was fairly near, in primary responses to this question. "Travel" led the list, followed by "spending as much time as possible with my family," and "pretty much the same activities I'm doing now." Contrasts, nevertheless, did show themselves in secondary choices. "Helping others," and "making peace with God" were mentioned rather forcefully by seriously ill patients but were relatively rare in the choices of the healthy persons, who favored "creating and accomplishing something."

Preference for travel suggests that time's passage can be arrested and death's threat blunted by drinking in life in huge swallows. "Spending time with one's family," and "the same activities" express the desire to hold on to the living and to the security of the familiar, which most of us find of some comfort when we get into difficulties. The secondary theme of "helping others," obvious in the patients, conceivably serves to diminish feelings of isolation and incapacity, and gives the ill person permission to ask and expect reciprocal action from others. "Peace with

God" reflects the need of some to expiate sins and do right by their fellowmen in expectation of an oncoming Divine judgment. Studies of mentally ill patients, by this writer, indicate that their characteristic choices tend to give priority to activities of a social and religious type, e.g., "give my belongings to charity," "stop war if possible," etc. This is in contrast to the choices of normal groups, which emphasize personal pleasures and gratifications. Undoubtedly, the responses of the mentally ill can reflect their above-average feelings of guilt and aggression.

How do people prefer to die?

The writer queried groups of normal persons, mentally ill persons, seriously ill patients, and terminally ill patients on this point. All summed up their desires as follows: "quickly, with no suffering; in one's bed, at home; sleeping, at night."

In preferences for methods of death, there are, of course, personal idiosyncrasies, e.g., by drowning because "it would be cleansing." There are other revealing facets in the preferences given. The thought of "quickly, with no suffering" voices the wish to avoid pain and the dehumanization caused by the lingering illness that creates the dependent person who no longer can maintain his pride and dignity.

"In one's bed, at home" accents the psychological wants most of us have for security and for familiar places and people when we are enmeshed in the afflictions of life.

The idea of "sleeping, at night" connotes a tranquil end to one's existence, with little bother. There are, nevertheless, other overtones. If you die at night, others cannot see your weakness so clearly, and you die decently. On a symbolic level—if you don't know that death has come, perhaps it is not happening at all. Additionally, heretofore, the experience of awakening from sleep has always taken place—who knows? And finally there is the notion of having lived up to the very end—of having taken everything the day had to offer.

In response to the other side of the coin—"How would you not like to die?"—the concept of "nonviolently" cuts across all the groups—and is not limited to the mentally ill group as this writer had found in a previous pilot study. Once more, it is not the desire to evade pain that is governing this preference, but the idea of preventing body mutilation and destruction of one's body image. This is as true for the nonreligious individual who envisions the end of man as "dust unto dust"

as it is for the religious person who has faith in a bodily resurrection in the future.

One wonders whether these responses do not disclose, on some plane, a reaction to our modern way of dying. No longer do most of us die in the privacy of our homes with family about and comforting us, and with a minimum of medicine that can prolong life. We die in the "big" hospital with its impersonal intravenous tubes and oxygen tents. It is as if death's reality were being obscured by making it a public event, something that befalls everyone, yet no one in particular.

How do people prefer to be buried?

Most people want to be buried in a cemetery grave because "it is the conventional, usual way," or "I'll feel secure—be with my family," "I won't be lonely." A minority prefer cremation because "there's no fuss," and "it's sanitary." Some mentally ill patients choose cremation because "it will get this bad thing out of me once and for all." Again there are personal variations, e.g., "in a mahogany oak vault because it will be certain to keep out spiders."

On the whole, most people do not want to be cremated when they are buried because "you disappear as a person," "it is against my religion," "you are forgotten more easily that way."

Is there a certain type of individual who is more ready than most people to die for a principle or an ideological cause?

This is not quite clear as yet. Circumstances, social and cultural conditions, along with personality factors, undoubtedly are influential. For some, the *manner* of death, rather than the mortal character of man, is the key to the fate of the individual spirit. Edward Norbeck of Rice University, for example, has indicated that among the ancient Aztecs, the souls of warriors and male captives who were slain in sacrifice to their gods went to the most desirable of several available heavens. Those who died from sickness or in generally undistinguished fashion were assigned to a lower-grade heaven.

The orientation of others who die for a principle or cause is that since life is short and one dies with many desires unsatisfied, life should be dedicated to sacred or worthy goals which, if necessary, are to be valued above life. Individual life is renounced so that the life of the group or movement can continue. One recalls Lawrence Oates, the English captain, tottering out deliberately to die in the frozen desert

so that his companions, who were hoping to return from the South Pole, might have more food. Psychologically, this type of individual, by identifying himself with certain cultural or religious values, feels that he avoids social isolation in eternity. He challenges death by emphasizing the omnipotence of a movement or cause. There is, additionally, the feeling of triumph over death because he gives up his life when he chooses. The individual, in one sense, has made himself master over death. In another, he underlines the statement of the Chinese philosopher, Lao-tze: "Who dies and dying does not protest his death, he has known a true old age."

Why do some men seem to have no fear of dying in war combat?

Most soldiers are actually afraid of dying in combat but learn to control or repress their fears. Colonel Albert J. Glass of the armed forces, after observing American soldiers during the Korean War, stated that combat personnel ward off anticipating fears by the use of a number of defenses: (1) adoption of a fatalistic attitude, (2) the myth that they are invulnerable or immortal, (3) use of superstition and magic, (4) religious belief and faith, and (5) apathy. These coping techniques make the soldier feel, at least for the time being, that death cannot happen to him. In a similar vein, Roy R. Grinker and John P. Spiegel, studying pilots during World War II, found that those who did not "break" while in air combat, as compared to those who did, retained for themselves the psychological illusion of invulnerability. There is apparently a need to face death, and also a need to turn away from it, if we are to function maximally.

What is the relationship of religious belief to anxiety about death?

Religion is a major way of dealing with the problem of death. It has often been assumed that religious belief is effective in reducing anxiety about death. There is, however, no direct experimental evidence to bolster such a contention. Actually, investigations by Irving E. Alexander and Arthur M. Adlerstein demonstrate that "religious solution to the problem of death is no more effective in reducing anxiety than is a nonreligious solution."

The writer of this article, in his own studies thus far, finds the religious person, when compared to the nonreligious individual, to be more afraid of death. The nonreligious individual fears death because "my family may not be provided for," "I want to accomplish certain

things yet," "I enjoy life and want to continue." The emphasis is on fear of discontinuance of life on earth—what is being left behind—rather than on what will happen after death. The stress for the religious person is twofold: (1) concern with afterlife matters—"I may go to hell," "I have sins to expiate yet"; (2) concern with cessation of earthly experiences.

The data indicate that even the belief of going to heaven is not a sufficient antidote for doing away with personal fear of death in some religious persons. However, there is no question that for certain people religion does provide security and support in meeting oncoming death. Gordon Allport of Harvard University thinks that when religious commitment is scrutinized more closely, two opposite trends may become evident. People whose religious values are "intrinsic," that is, comprehensive and integrative in their lives (true "ends in themselves"), will be less afraid of death in contrast to those with "extrinsic," that is, defensive, escapist, ethnocentric (race or nationality oriented) religious values.

Does the funeral ceremony have any psychological value?

Rites performed for the dead have important effects on the living. The funeral can serve many purposes: (1) disposing of the corpse, (2) paying respect to the deceased, (3) assuaging the grief of the bereaved, and (4) bolstering the solidarity of the social group. David G. Mandelbaum of the University of California notes that American culture has, in certain respects, become "deritualized." In the nineteenth century American culture tended to be somewhat overexpansive about bereavement; in the twentieth century, formal death ceremonies may have become too cursory. Many persons bereaved by a death find they have no clear idea about what to do next.

Death ceremonies, like other cultural expressions, tend to be modified in time as a result of changes in the cultural and psychological atmosphere. Robert L. Fulton of Los Angeles State College has studied Catholic and Protestant clergymen's attitudes toward the funeral. He reported that many Catholic priests view the ceremony mainly as an instrument of prayer for the salvation of the soul. The funeral honors both the memory and the body of the dead person. It also provides a reminder to the bereaved to prepare for their own eventual death. The Protestant clergy sees the ceremony mainly in terms of the peace and understanding it brings to the survivors. Its purpose is primarily to

comfort the living. It is, of course, also seen as a means of emphasizing the hope of a future life.

Edgar N. Jackson, who has studied the field of grief and religion, feels that modern psychological understanding verifies the value of religious rites, such as the Jewish shivah and the Irish wake, that fortify the individual against the stress of grief during mourning. The funeral contributes a framework within which feelings and emotions can be freely expressed. It provides a means with which to help break ties with the dead person and to face the reality of the situation. Honest sorrow, openly expressed, is nature's own bridge from disaster back to normal life.

Is there any scientific theory for or against the idea of immortality of the soul?

The findings of science say nothing for or against survival of personality or the soul after death. Direct experience, observation, or controlled experimentation is difficult, if not impossible, at least at this stage of our knowledge. The evidence is unknowable in an empirical, scientific sense.

Through the years, a good deal of investigation has been carried out on psychical phenomena where apparent communication from one mind to another occurs through other than known sense channels. Recently Karlis Osis of the Parapsychology Foundation, studying reports of deathbed observations by physicians and nurses, suggested that their information seems to point to some kind of existence after death. Frederick Myers, in his book *Human Personality and its Survival of Bodily Death*, also implies that certain well-documented events can only be explained on a paranormal basis. He concludes this after discounting many supposedly reported psychic phenomena that he feels can be explained as trick manifestations of the mind. Intensive studies done over the years by the Society of Psychical Research (British) and the American Society for Psychical Research have led them to announce that there is a considerable volume of carefully validated material about the possibility of life after death, and that although this material does not fit into any well-established or prevalent psychological system, it must not be ignored.

Carl Jung, the famous psychoanalyst, thought that "the psyche impinges on a form of existence outside of space and time as we know it and presents a scientific question that deserves serious consideration." This view is additionally supported by respected thinkers such as Gard-

ner Murphy, J. B. Rhine, C. J. Ducasse, F. J. M. Stratton, and the late William James. In this connection, it is interesting to note that a 1960 poll by the American Institute of Public Opinion showed that 74 per cent of the United States population say "yes" in response to the question of belief in a "life after death."

There is no doubt that many persons derive great comfort from their belief that the soul survives death. There is also no doubt that psychology must begin to digest certain parapsychological findings. However, psychology still lacks the scientific and intellectual equipment for adequately evaluating telepathic (apparent communication from one mind to another by some agency other than recognized organs of sense) data and their bearing on the nature of the mind. The data presented us, on the whole, fail to meet certain criteria that the scientist uses in his professional pursuit of knowledge. It is quite conceivable, of course, that our science-conscious culture, which tends to measure all experience within the bounds of space and time, does not furnish us with all the dimensions necessary for investigating and understanding death.

How prevalent is fear of death in normal people? In the mentally ill?

Gregory Zilboorg, a noted psychiatrist, has stated that fear of death is "present in our mental functioning at all times." Melanie Klein, the English psychoanalyst, believed that fear of death is at the root of all human anxiety. Paul Tillich, the renowned theologian, bases his theory of anxiety on the orientation that man is finite and must die. The Austrian psychiatrist, William Stekel, went so far as to express the hypothesis that every fear we have is ultimately a fear of death.

People dread not only the physically destructive aspects of death but also the expected loss of consciousness and self-control that it implies, as well as the loneliness and stamp of failure to which it may doom them. Others fear the forfeiture of their identity, their past and future, in addition to their present. Belief in some form of immortality, of course, changes this attitude. Some persons die with less fear and greater acceptance of death than others because they accept it as the curtain on a well-acted play, as a means of reunion with loved ones, as a permanent resolution to their conflicts and suffering, as a gateway to a new life.

It is worthwhile to note that in certain people fear of the *process* of dying may be more frightening than the idea of death itself, because of its association with extreme dependency, shame, progressive dehu-

manization, and the experiencing of pain. In this connection, the findings of Sir William Osler, the distinguished physician, are relevant. He stated that the great majority of patients seldom suffer much when they are on the threshold of death. The sting of death may be more in anticipation than realization.

Fear of death is not only a basic source of anxiety but can also be a way of binding together fears of separation, mutilation, and abandonment. It can be a derivative or symbolic equivalent of the inability to handle life problems. In opposite fashion, fear of death itself can be masked in neurotic symptoms or in somatic complaints. For example, Adolph Christ of the Langley Porter Clinic, San Francisco, found that concerns about death are related to neurotic tendencies in some older patients. Fear of death can be disguised in the depressed mood, in overconsideration for one's family, in fears of loss in general, in the fear of leaving one's house, or flying in an airplane, etc.

Psychological symptoms can become the road unconsciously taken by certain patients to deny fear of death. The writer of this article holds the hypothesis that one of the intentions of schizophrenic denial of reality is a magical holding back, if not undoing, of possible death. If living leads to death, then death can be warded off by not living. A number of psychoanalysts are of the opinion that one of the main reasons why shock measures produce positive effects in patients is that the treatments provide them with a kind of "death and rebirth" fantasy experience. The degree of mental disturbance (of itself) in patients, apparently, has little effect on their overall attitudes toward death; neither neurosis nor psychosis produces attitudes that cannot also be found in normal subjects.

What is the child's view of death?

During the last fifty years, various research endeavors have been carried out by workers in the field of child psychology. One is struck, however, by the slim, almost neglected attention given to the child's conception of death. This is all the more surprising since evidence suggests that it is in childhood that the adult's outlook concerning death begins to take on basic form.

The psychologist, Maria H. Nagy, has done some interesting work in this field. She found that there are three major stages of development in children's ideas about the nature of death. The first stage, which characterizes children between the ages of three and five, high-

lights the denial of death as a regular and final process. Death is a departure, a further existence under changed circumstances. Death is also envisioned as being temporary; indeed, distinction is made of degrees of death. Living and lifeless are not yet distinguished. The second stage, which typifies children between the ages of five and nine, indicates that death is personified (considered to be a person). He "even leaves footprints." The child accepts the existence of death; nevertheless, it is still remote and consequently not inevitable. Death is visualized as something that happens to someone else. Finally, in the third stage, which becomes prominent in children in their ninth and tenth years, death is recognized as the end of physical life. The child realizes that death is a process operating within a person and is inevitable and universal. Paul Schilder and David Wechsler make the additional point that in certain children death is conceived as a form of punishment for having hostile feelings toward others. Still other children see the death of a parent, or an individual meaningful to them, as abandonment or rejection with ensuing loneliness, fear, and resentment.

Do children take pleasure in burial ceremonies for animals? Is this a healthy reaction?

One is reminded of the sensitive French film of a number of years ago called *Forbidden Games*. In it, a child who has lost his parents as the result of a Nazi strafing raid, comforts himself by playing a game of funeral. Playing at and actually burying dead things helps the child to relive, digest, and ultimately, to master the shock of the death of a person, or even the animal involved. Doing something in the form of a ritualistic observance brings comfort and helps tide the child over the difficult period of mourning his loss.

Can the reaction to the death of a pet be similar to that of the death of a human?

Yes, and there is a revealing story told by W. H. Hudson in his autobiography, *Far Away and Long Ago*. As a young boy, he was thrown into consternation by the death of an old dog whom his family loved. This was because he realized for the first time that death must come to all. Such an experience can also provide a means of increasing mastery and intellectual control over the tremendous emotional turbulence that the death of a loved one stirs up inside us.

What should a child be told about death? What measures can be taken to prevent adverse reactions?

Children are usually shut out from two great mysteries of life: birth (sex) and death. We have come to recognize the mental hygienic aspects of being honest in answering questions about birth. Research studies and clinical experience direct that we do the same for the topic of death. We do not protect a child by hiding from him the realities of death; we only hinder his emotional growth. Death is ordinarily mentioned in whispers, and its accompanying experiences are made alien to the child. It consequently becomes something to be afraid of, something unnatural. This orientation probably mirrors the adult's or parent's own anxieties and strong emotions about death more than the child's actual ability to handle the impact of death.

Charles W. Wahl of the University of California at Los Angeles has pointed out that the classic adult defense against coping with children's questions is the assertion, maintained even by some professional personnel, that children cannot have a conception of death in any form; hence, they do not need to be reassured about it. One is reminded, he continues, of the certainty of a generation ago that the child had no sexual feelings and that, therefore, problems about childhood sexuality made no sense. The research data and clinical observations of such workers as Sylvia Anthony, Charles W. Wahl, Earl Loomis, Jr., and Maria H. Nagy, among others, belie this view.

It has been demonstrated that many of the child's obsessions, anxieties, and other neurotic symptoms are related to fears about death and serve as symbolic ways of fastening their concerns in this field. Edgar N. Jackson, in his book *Understanding Grief,* indicates that children, even at an early age, are more able to withstand stress brought on by their limited understanding of death than they are able to withstand mystery and implied desertion. Fears tend to be intensified when one cannot obtain direct factual information and when questions are met with evasion and subterfuge. Recognition by the child of the truth concerning death helps him make sense of the world and this recognition then becomes a source of strength rather than weakness.

Earl Loomis, Jr., Director of the Program in Psychiatry and Religion of the Union Theological Seminary in New York, states that children should share with their families those experiences associated with death. He feels that the more realistically, and the more in relation to the family, death is handled from early childhood, the better. Acts that

deny death or exclude children, or any family member, from participation and interaction with the dying person are also bad. Naturally, if hysteria, great confusion, or suffering is involved, factors such as timing and dosage must be considered. In broad perspective, what is honest and helps sustain the reality sense of the child will ordinarily prevent a child's adverse reaction to death.

Should seriously ill and dying patients be informed of their condition? Are psychotherapeutic aspects involved?

In this writer's own research, the great majority of seriously ill and terminally ill patients he interviewed wanted to be told the truth about their condition in order to "settle affairs or make various financial and family arrangements," and because "I have a right to know. It's my life," "would do what I really want," "would respond to treatment better if I actually knew what I was up against," "would know why I was suffering," "would have time to live with the idea and learn to die," etc. Most of them prefer honest, plain talk from physicians and family about the seriousness of their illness. They don't want their problems and fears ignored, nor do they want reassurances that are lies. When they can talk about their feelings concerning death, they have a sense of being understood and helped rather than becoming frightened or panicky. There is truth in the idea that the unknown can be feared more than the most known, dreaded reality.

Of the small minority who did not want to know, 15 per cent said this was because "it might take away hope and my will to fight," "it might worry and upset me," "I'm afraid of what I might do."

A substantial number of physicians state that they never tell their patients they have a serious illness from which they will die. Others indicate that they would tell only under unusual circumstances. The reasoning is that this information will take away hope and frighten the patient with a consequent worsening of his condition. A growing minority report that they do inform their patients. Some of these, however, consider it preferable to wait until the patient himself asks about his prognosis. Others in this group say that certain patients actually do better if informed about the severity and nature of their disease. In fact, some recent studies do imply that terminally ill patients, when told of their prognosis, reveal an adjustment equal to or better than that observed in groups of matched patients, similarly treated, who have not been so informed.

Claude Forkner, former president of the New York Cancer Society, states, "I have not encountered a patient being seriously damaged by

telling him the truth." Naturally, how the telling is done is important. Truth can be cold and cruel, or it can be gentle, merciful, and hopeful. Telling must be suited to the needs and character of the individual patient. An interesting contrast emerges in comparing studies of physicians and patients about whether to tell or not to tell. Depending on the specific study, 69 per cent to 90 per cent of physicians favor not telling. In opposition, 82 per cent to 89 per cent of the patients want to know.

There are consequences of a psychotherapeutic nature implied by some of these findings. When the patient is permitted to discuss his concerns about death, he feels less alone. He is comforted by knowing that people understand him and will stand by him. Some patients can suffer more from abrupt emotional isolation and unwitting deprivation than from the illness itself. Many feel grateful not only because they can put their houses in order but also because they have time to make confessions, either sacramentally or informally. Additionally, the opportunity to talk about their feelings helps subdue irrational fears and guilt associated with the thought of death.

It is a fact that many hopelessly sick people feel guilty. This results from a number of reasons: (1) They often express the suspicion that their sickness and fate are self-inflicted and their own fault. (2) They assume, more or less, the role of the utterly dependent child. Some consciously apologize for the trouble and "fuss" they are causing. Our culture fosters a sense of guilt in most of us when we are placed in the dependent role. (3) This is further extended in the dying person because of his feelings that he is forcing the persons around him to face the necessity and finality of death, for which they will hate him. (4) Closely allied to this is the sick person's dim awareness of his envy of those who remain alive, and of the wish, rarely entering consciousness, that the spouse, parent, child, or friend die in his stead. It is possible that it may be this wish, in part, that breaks into action in those cases of seriously ill people who kill not only themselves but also their family and neighbors. On the other hand, the living respond with guilt of their own for being alive and seeing someone else die, and perhaps for even wishing that the dying person hurry along on his way. In truth, most healthy people feel anxious and guilty at seeing someone else die.

What measures can be taken to enhance management of the dying person?

Gerald J. Aronson of Beverly Hills, California, suggests four rules for physicians:

(1) Do not tell the patient anything that might induce psychopathology. Here your only guide is your clinical feel and the response of the patient to your comments and manner as you have been slowly going along with him in the course of his illness. (2) Hope must never die too far ahead of the patient; either hope of getting better, or hope of conversations tomorrow, etc. (3) The gravity of the situation should not be minimized. Is this inconsistent with rules one and two? The patient will not fail to understand from your demeanor that his situation is serious. If you are Pollyannaish, he will become suspicious, press hard for an answer, feel cheated, and lose trust. But if you are serious, between his potential psychopathology and hopelessness and his mistrust in you as a physician, he will feel grateful, informed within the limits of his toleration, and human—not a vegetable. Goethe once said: "If we take people as they are, we make them worse. If we treat them as if they were what they ought to be, we help them become what they are capable of becoming." This requires great tact and finesse. It is to tell the patient about his impending death in such a way as to avoid his just idly sitting around awaiting death. (4) You must try to stimulate the duration of a man's psychological present. If, to a dying patient, the psychological present stretches three months long, arrange to tell him in such a way and at such a time so that this time may be purified of the idea of death and hence still be a field of activity.

One of the greatest challenges to the physician is his duty to help the patient die comfortably when death is inevitable, just as it is his duty to prolong life when there is hope of recovery. Ministry to the dying is extremely difficult if we·ourselves are not quite reconciled to the idea of personal death. Our embarrassment at looking at the individual face of death forces the dying person to live alone on the brink of an abyss, with no one around to understand him. One is reminded of Tolstoi's Ivan Ilyich; we do not even permit him to say good-by to us. The ensuing results are all too often self-pity, depression, occasionally even psychosis.

Our summons is to help the person re-create a sense of significant being for himself, to be an individual even though dying. Advantage should be taken of his religious or philosophic outlook to help him integrate his life as it has been lived and to accept the idea of his death. Catharsis can be obtained by means of confession, making him less regretful and self-punishing, and relieving guilt and depressive feelings. What is done for the patient must be in the context of facing the fact

of his physical disintegration, while continuing to accept him without rejection or abandonment as a human being with an identity.

What are physicians' attitudes toward death? Are they more afraid of death than laymen?

One of the unsuspected obstacles to this writer in conducting research in this field has been the attitudes of certain physicians. Death is regarded as a dark symbol not to be stirred, even touched—an obscenity to be avoided. He remembers reflecting how paradoxical it was that the problem was turning out to be not the patient, but the physician, and that the researchers, propelled most likely by the same anxieties regarding death as the physician, should end up on an opposing side.

A hypothesis that this writer holds, which is continually being strengthened, is that one of the reasons certain physicians enter medicine is to control their own above-average anxieties about death. August Kasper of Beverly Hills, California, has indicated that the doctor takes his own fears about death, puts them as intellectual questions, and tries to answer them for other people. In this respect, Phyllis Bottome's biography of Alfred Adler is germane. She relates that at the age of five, he almost died from pneumonia. His own doctor had given up hope for his recovery. The fears generated by this led the boy to the resolution that, when he recovered, he himself would study medicine. In that way he would be able to defend himself against the danger of death. Control of his own anxiety would be obtained by having the power to cure.

This writer has completed a pilot study on the attitudes toward death of a group of physicians. The group consisted of thirty male physicians, mostly internists and a few surgeons, with an average age of 39.2 years. The results show that physicians *think* about death less than do control groups of patients and normal subjects. Counterphobic attitudes toward death and relief from unmitigated tragedy are undoubtedly at work. Provocative, nevertheless, is the additional finding that the physician group is more *afraid* of death than either the patients or normal subjects. This writer submits that some physicians often reject the dying patient because he reactivates or arouses the physician's own fears about dying. In some physicians, guilt feelings tied up with death wishes toward significant figures in their own lives play a role. There is also wounded narcissism and lack of gratification in the physician, whose function is to save life, when he has a patient who repre-

sents a denial of his essential skills. Even psychiatrists seem reluctant to talk or write about death. And in the textbooks of psychology, there is not a paragraph on the topic of death.

There is no question that our own sensibilities about dying and death are showing here. From his own experience, the writer knows that few undertakings in psychological research are more emotionally exacting than working in the field of death. Pertinent to one's research labors is not only the emotional resistance to the investigator, but also the potential emotional blind spots of the researcher himself. The investigator is confronted with the problem, on the one hand, of being emotionally swamped—the reactivation of his own anxieties about dying, antipathy toward or overidentification with certain kinds of patients, the sense of triumph of outliving some, and guilt over inability to help others—and, on the other hand, with overintellectualizing his approach and hiding behind a facade of pseudorigorousness, refusing to observe any but the most obvious and least emotionally tinged dimension of what is happening. Research on human behavior in extreme situations calls for a delicate balance of identification and intellectual detachment. How much more is demanded of the physician who is in constant everyday contact with the problem!

Do people have a "death instinct" or "death wish"?

Some psychologists have postulated the existence of two basic forces operative in man: Eros, the life instinct, and Thanatos, the death instinct. Freud, in his *Beyond the Pleasure Principle*, stated that the death instinct is a force that dominates life and that the goal of life is discovered in death. He related this to tendencies we have toward self-destruction and aggression. When the death instinct is turned inward it results in suicide; when turned outward, in murder. "Life," he said, "was a circuitous way to death. Yet the paradox is that the living organism resists, with all its energy, changes that could help it reach its life goal by a short way."

Certain investigators contend that some people have a "death wish" that they feel represents a need for self-punishment or expiation of sins with respect to oneself and others. The intriguing speculation and argument for a "death instinct" is not acceptable to many investigators. A good proportion view death as a deficiency of living structure to hold out against noxious external agents rather than as inevitable realization of an innate thrust toward death. Death, they state, is failure of life, not its fulfillment.

What is "voodoo death"? Sudden death?

Reliable investigators have substantiated that apparently healthy people, under the influence of a hex or voodoo, can die within less than twenty-four hours despite all efforts to save them. Autopsy findings have discovered little organic disease to account for their deaths. S. M. Lambert of the Western Pacific Health Service, Rockefeller Foundation, has related that "bone-pointing," or "conjuring" against a person, can cause death by fear. Just recently, R. J. W. Burrell of the Bantu Cancer Registry in Capetown, South Africa, reported similar instances of sudden death among the Bantu in the Transvaal. This is not necessarily limited to so-called primitive peoples. Thomas Hackett and Avery Weissman, of the Massachusetts General Hospital and Harvard Medical School, have recently cited cases where patients predicted their own death in the near future and then died when there was seemingly little medical reason for this to happen.

The medical literature discloses instances of sudden death occurring under a great many different conditions and in individuals of all ages. Death as a result of fear, sight of blood, hypodermic injections, etc., is well known. It is true that in a good proportion of cases autopsy has revealed previously unsuspected heart defects or other pathology. In many, however, no pathology has been found on extensive and thorough postmortem examinations. In voodoo death, physiological changes in the body appear to have been triggered into motion by psychic and emotional factors. Curt Richter, of the Johns Hopkins Medical School, suggests that these people die from a reaction to hopelessness. Their adaptive mechanisms are so challenged that the resulting disintegration leads to total maladjustment and death.

Has there been a change in attitudes toward death in the past generation?

Geoffrey Gorer, the English anthropologist, points out that in the nineteenth century most of the Protestant countries seem to have subscribed to the Pauline beliefs concerning sinfulness of the body and the certainty of an afterlife. With the weakening of these concepts in the twentieth century, there appears to be an accompanying decrease in the ability of people to contemplate or discuss natural death and physical decomposition. Sickness has now become preventable and curable, and its companion, death, might seem almost equally vulnerable to science and medicine.

Robert L. Fulton of Los Angeles State College intimates that fear of death is no longer so much the fear of judgment as fear of the infringement taking place upon our right to life, liberty, and the pursuit of happiness. We cope with death by disguising it, pretending that it is not the basic condition of all life. Funerals are arranged for the living, not the dead. The whole nasty business of death and departure is given over to the hospital and funeral parlor. It is now a rare phenomenon for the average individual, outside the medical and nursing professions, to see an untreated dead person. Contact with the dead is permitted only in a formalized manner. Natural death has become uncomfortable for us to contemplate.

Nevertheless, the assault of the two world wars together with the possibility of a nuclear holocaust have tended to push life's fleetingness more into the foreground. The existentialist movement has been particularly conspicuous in rediscovering death as a philosophical theme in the twentieth century. In this regard, Hans I. Morgenthau has pointed out that one of the distinctive characteristics of our secular age has been replacement of the belief in personal immortality with belief in the immortality of the world man leaves behind. Even this, he provocatively emphasizes, is now threatened by the possibility of an H-bomb war. Such a war could destroy not only the individuality of death but social immortality as well, by making both society and history impossible.

Do Americans refuse to face the fact and meaning of death?

In the United States concern about death has been relegated to the tabooed territory heretofore occupied by diseases like tuberculosis and cancer and the topic of sex. We have been compelled, in unhealthy measures, to internalize our thoughts and feelings, fears, and even hopes concerning death. In the presence of death, we have tended to run, hide, and seek refuge in the development of an industry that has a major interest in the creation of greater "lifelike" qualities in the dead, in group norms, and actuarial statistics. Even the words for death and dying are bypassed in much of everyday language by means of euphemisms. It is not the disquieting, "I die," but rather the anonymous, "one passes on," "one ends his days." We "exit," "cease," become "defunct" or "demised," but rarely die. The military makes death impersonal, and prevalent entertainment treats death not so much as tragedy but as dramatic illusion.

There is no question that profound contradictions exist in our thinking about the problem of death. Our tradition assumes that man is both terminated by death and capable of continuing in some other sense beyond death. Death is viewed, on the one hand, as a "wall," the ultimate personal disaster, and suicide as the act of a sick mind; on the other hand, death is regarded as a "doorway," a point in time on the way to eternity.

Death is not acceptable to many Americans because of the strong feelings we have about the uniqueness of life and the finality of death. Illness and death are considered not just as bad fortune but possess overtones of personal failure and loss of status and identity. Generally speaking, Oriental man has a less frenetic approach to his own individual death because of philosophies that predicate a series of existences available to him in the future.

Death is one of the essential realities of life. To deny or ignore it, distorts life's pattern. Attempts to expel death or not to take it into account are a deception committed by man on himself. To completely understand ourselves, we must confront death, become aware of personal death.

What measures can be taken to prevent adverse reactions to death?

(1) We must realize, emotionally as well as intellectually, that dying and death are not just statistical eventualities of old age but are possible all the time. We must give up the illusion that death is an unfortunate accident that need not occur.

(2) We prepare for living—why not for dying and death? Having a philosophy of life and death, be it existential, inspirational, or transcendental, can be extremely helpful and sustaining when we confront death.

(3) Expression of grief through wakes, shivah, etc., should be encouraged. As a rule, they provide a healthy channel for the bereaved and tend to minimize the possibility that nervous manifestations and guilt feelings will erupt later.

(4) People should have an overall concept of what serious illness can mean and what these illnesses can demand from them in physical, economic, psychological, and social terms.

(5) Finally, there is a pressing need for more research in this field. We need more reliable information and systematic, controlled studies. Further examination can enrich and deepen our grasp of adaptive and

maladaptive reactions to stress and of personality theory in general. Research on the meaning of dying and death can enhance our understanding of the individual's behavior and provide an additional entry-way to an analysis of culture.

Man's capacity to grasp the concept of a future—and inevitable death —may play a role in present behavior more commanding than we have been inclined to recognize. Herein lies the summons to advance our comprehension of how the thought of death can serve life.

DEPENDENCE

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What is dependence?

Dependence is the relation of having existence conditioned by or contingent upon the existence of something or someone else. It is the condition of resting in faith and confidence upon something or someone, and implies, also, reliance upon someone else. Implicit in dependence is the fact of subjection, subordination, or belonging to someone else. The dependent person may exhibit degrees of helplessness and passivity which engender the dependence and which perpetuate it. Dependence is the opposite of independence, which means exemption from external control and support as well as individual liberty of thought and action. Independence is a state of freedom from bias or the undue influence of the opinions and actions of others. It is the ability to think and act for oneself.

A reasonable dependence on others is one of the recognizable characteristics of emotional maturity just as excessive dependence can be characteristic of the immature person. An overdependent individual may be unable to make decisions for himself, and his dependence may serve to protect him from the real or imagined hazards of a courageous, independent existence. The maturing person however, tends to recognize that there are times and circumstances in which it is wise to rely upon others, to take pertinent advice, to make one's own decisions, and to take responsibility after consulting others. Moreover, it is important to receive as well as to give, and all interpersonal relationships involve mutual trust and interdependence. This is true in domestic relationships, in work, and in social situations. Some people find it extremely difficult to receive from others or to depend upon them. To such people, dependence connotes personal inferiority and failure of strength and power. This can be a reaction to dependence. Some react

by overwork and by inordinate planning for future security. For such individuals the joy of receiving is well nigh impossible.

Independence is also a quality of emotional maturity. Normal independence does not mean the need to dominate or to control others but rather the ability of a person to take action on his own when this is necessary, to assume responsibility and to express himself and feel himself to be a person in his own right. A healthy balance between dependence and independence is one of the hoped-for goals of human development. This balance is seen in the normally maturing person in whom we also find a growing capacity to deal with life in terms of reality, to cherish long-term values, to develop an adult conscience, to love unselfishly, to control anger and hatred, to handle unacceptable impulses and conflicts, to adjust in a wholesome manner to sex, and to find satisfaction in productive work.

What causes dependence? What determines the degree of dependence?

Biological as well as cultural and direct experiential factors cause dependence. A baby comes into the world in a condition of biological helplessness and would soon perish if his parents, especially his mother, did not care for him. The infant can be thought of primarily as a metabolic and hormonal system that receives from the environment sensory energy which influences the sense organs of touch, heat, cold, and pain as well as the sensory receptors to light, sound, vibration, motion, and position change. All these influences impinge upon him. He experiences hunger and thirst. He performs, at first, few-purposeful skeletal body movements except sucking and those associated with excretion—and even these seem relatively unconditioned. The baby is very alive and reacts intensely by crying and, later, by laughing, but he is apparently passive and is indeed actually extremely dependent. His physical dependence upon his parents for food and care generates a related emotional dependence which at first is focused on the mother. This is especially true in American culture based upon a small family unit and may be contrasted with the more diffusely directed dependence in some so-called primitive cultures.

In our culture, the mother is the one most concerned in the development of the basic socialization of the child. As the baby grows through infancy, he gradually begins to recognize his mother as a separate person, and realizes his dependence upon her, and comes to take refuge in her in time of trouble. She gives him solace and a sense of security. The father, too, serves to protect the child from the hazards and insecurities

of a large and unknown world. If the young child's security is threatened, as by separation from his parents or their failure to respond to his needs, the child may become disturbed in a variety of ways. It is primarily through dependence upon, and trust in, the parents that it is possible for a child to grow and to adapt himself to the requirements of the world. Some degree of dependence is, therefore, essential in normal development.

Overdependency may result from the failure, unwillingness, or inability of the parents to promote the child's growth. The degree of dependence is conditioned by early affectionate relations with the parents, early training and discipline, and the parents' wisdom in permitting the child to exercise initiative, creativeness, and imagination consistent with his abilities. Parents with a need to dominate may use their children as objects for the expression of their need for superiority by controlling their children excessively. On the other hand, a failure to provide loving discipline may leave a child insecure and anxious. Children growing up in a healthy family environment make the transition from dependence to independence gradually.

Probably the best educational philosophy is one which recognizes that childhood with its varying degrees of dependence and independence is a significant and important time of life and that also the child's expression of growing independence need not be accepted as final. It is important that a child be given the opportunity to grow, but at the same time, the child should recognize that the insights he reaches as a child will be amplified and enlarged as he grows up, and that this process of widening horizons need never cease in his life.

What determines the kind of dependence? What determines one's dependence on a parent, a mate, a friend, certain modes of life?

Dependence can be normal or abnormal and the kind of dependence is determined by biological factors such as sex and physical illness, and social factors such as family pattern, customs of child rearing, and attitudes and practices of education and training. The child's dependence upon a parent is conditioned by the parent's capacity for fostering growth, for recognizing normal fluctuation in dependence needs and giving loving support and discipline. When a child is deeply dependent upon the parent in an emotional relationship and yet feels unwanted, unloved, and rejected, he will suffer anxiety and may react to this in many ways. He may become permanently embittered,

hostile, or fearful, or may never be able to achieve independent status and may cling to a parent or parent substitute even as an adult.

One's dependence upon a mate is determined by previous experience and upbringing as well as conscious and unconscious dependence needs which may be important factors in choosing a mate. For example, some spouses may in subsequent marriages choose the same kind of dependent, helpless partner; some individuals appear to prefer a mate who is passive, clinging, inferior, and inadequate. Others, on the contrary, seem to seek a spouse who is dominating, blustering, and even punishing.

Dependence on a friend may also be determined by character defects but, as in the case of a happy, healthy marriage, the formation of a friendship properly involves interdependence, cooperation, and mutual helpfulness. A wholesome friendship requires willingness to compromise, ability to see another's point of view as well as one's own, and the capacity to give as well as to receive affection.

Dependence may be determined variously by certain modes of life, and a good example is service in one of the armed forces. A young man who finds himself inducted into the service discovers himself surrounded with multiple restrictions and the necessity for behaving in the same way as hundreds of others. There is limited opportunity to express his uniqueness and his own individuality. He may at first react to this by a feeling of overwhelming defeat, loneliness, and a sense of being beaten down. Separated from his own family and friends, he is forced to conform. Little by little, he learns to express his personality and may find security and protection in being a part of an organization so much larger than himself that provides him with food and clothing and spares him from many of the responsibilities of life. Although he is forced to submit to the will of others in many ways, and although he may be rebellious, nevertheless, he may become dependent upon military life and may be lost and disorganized when he becomes a civilian again.

How does dependence manifest itself?

The normal child in a healthy family and community setting, like the normal young soldier in a well-run military organization, usually learns to accept dependence which permits him to enjoy security and freedom from unnecessary fear, and which provides an environment in which he can grow. If the parents of a child persist in overprotecting him or otherwise keeping him in a dependent, infantile state, the child

may surrender and may cease to try to grow. Such a child may become fretful, passive, submissive, weak, and petulant. Clinging to his mother's apron strings, he may never be able, even as an adult, to fend for himself and attain goals of his own choosing. Such a child may overidentify with a parent, may take on his or her patterns of disturbed character or emotional illness, and may remain immature. The parents of such a child may unconsciously combat efforts that the child may make toward an independent adjustment.

Once a child renounces his normal striving toward independence, he may come to enjoy his dependence even though he does so at his own expense through feelings of inadequacy, inferiority, and shame as he faces life with other children. Or he may defend himself against such feelings by boastful and aggressive behavior or by temper tantrums; or he may seek other ways of gaining his own way, showing power, and controlling others.

Dependence may manifest itself in adult life by patterns of denial of dependent urges and needs, so that the individual may be unable and unwilling to express normal dependence on his family and friends or his mate. Early dependence may be expressed also in irresponsible attitudes and behavior with disorganized patterns of living. In other individuals there may be alternation between hostile and domineering behavior, on the one hand, and irresponsibility, passivity, and depressed inertia, on the other.

The child who is denied the opportunity of normal growth to independence may express himself through rebellion. This may be a difficult battle for the child who becomes pitted against the will of his parents with his whole right to independent selfhood at stake. This may be a battle which is damaging for both parents and child, all of whom are unable to recognize what is happening. In some cases, the result is determined by the overwhelming pressure of the parents and/or the weakness of the child who may retreat into himself as the only possible route of escape.

What are the physical and psychological characteristics of dependence?

The overdependent individual may be vulnerable to psychosomatic illness which may be a form of self-punishment or a refuge. His helplessness may be perpetuated by the feeling that it will compel others to come to his rescue and to assume responsibility for the management of any current dilemma. Such an individual may feel safe only as long as he is sick and weak and unable to achieve success on his own.

In severe crises, such as physical illness, all persons regress to some extent and may become more childish and seek security in parent figures. This tendency, however, is greatly exaggerated in the dependent person who may repress his hostility completely and exhibit only a clinging reaction toward his parent or an exaggerated desire to appease and conform, with the winning of parental approval as his goal.

How does the removal of the object affect the one who is dependent upon it? What are the reasons for this reaction?

Many examples may be given of loss of the person on whom the individual is dependent. For instance, when death removes the parent from the child, or a spouse from his mate, or a friend from a friend, there is, at first, confusion and disbelief. This is followed by grief, loneliness, disorganization, and even fear. Where the dependence is abnormal, the person may transfer his dependence to another object or react in other ways. Alternately, removal of the object of dependence may stimulate the person to grow up. Another example of loss of the object of dependence is the frustration that may be experienced by the older child when a new baby comes. Unless such a situation is handled wisely, the older child may feel ignored by his mother and father. Deeply sensitive, he may seem to be deserted, and will react by becoming overly dependent or expressing his frustration by patterns of aggressiveness or through physical symptoms.

Can dependence be a symptom of another disorder?

Yes. The case of the child who expresses his frustration over being apparently deserted for the new baby by becoming overdependent is an example. Excessive dependence can be a manifestation of neurotic reactions; in physical illness, especially long-term illnesses, a child or an adult may retreat into overdependence.

Can dependence be a cause of another disorder?

Yes. Excessive dependence may lead to hypochondriasis, psychosomatic illnesses, psychosis, and a variety of psychological disabilities.

Can dependence be a motivating force? If so, why and how?

Wholesome dependence can motivate an individual to accept love gratefully, to have faith in the world around him and, therefore, to grow in his capacity to strive toward reasonable goals and devote himself to the welfare of others. As has been stated previously, the normal

dependence of a child toward his parents is the beginning of his socialization and growth as a person. On the other hand, abnormal dependence can lead to the need to please, to control, and to get one's own way by wheedling or by a show of temper.

Do all individuals feel a degree of dependence?

A degree of dependence is normal for all individuals; some feel it more than others as has been indicated.

In some cultures and at certain periods of history, women have undoubtedly felt a greater degree of dependence than men. The biological needs of women associated with pregnancy and childbirth and the care of children do determine somewhat greater degrees of dependency at certain times. However, apart from these special biological and cultural determinants, there is probably no *a priori* reason why women necessarily have greater dependence feelings.

As to age-groups, it is obvious that the infant and young child are dependent and a realistic recognition of this by the child is normal, provided it does not block wholesome development.

The aging person becomes more and more dependent upon others as his own physical energy becomes restricted. The older person may feel excessively dependent and may react to this by depression, loneliness and a sense of purposelessness, fear, and disorganization. For this reason, it is important that a person plan for older age by seeking and achieving new goals, enjoying the fruits of past achievement, filling life with meaningful activity within one's capacity, and by coming to grips with significant philosophical and spiritual questions.

National groups appear to show certain characteristics common to individuals. Some nations show greater degrees of dependence than others. A rebellious colony may battle to free itself of dependence and assert its own independence, and new nations may react against persisting traditions of dependence upon a parent country. Nations that have been enslaved or defeated by more powerful nations may react by a kind of national depression and by having a national policy based on submissiveness and conformity to the requirements of a dominant nation.

What are the treatments for extreme dependency? Have they been successful?

Treatments for extreme dependency are based upon either (1) a direct attack upon the central underlying problems such as the parent-

child relationship by long-term supportive, educational, or insight ther-
apy, or (2) satisfaction of the frustrated dependence in a more normal
way. Too often, unfortunately, the direct approach to the basic prob-
lems is not feasible because either the mother or the father or the child
may not be able to accept this. An example of the technique of trying to
satisfy dependence needs in some other way is the case of a person who
loses by death an older relative on whom he is extremely dependent.
Following such a death the patient may become insecure and feel lost
and bewildered, and may develop physical symptoms. A person like that
no longer has the one on whom he was able to focus his dependent
needs. One aspect of treatment in such a case is to provide another
person or persons to take the place of the one lost. Replacement therapy
may tend to perpetuate the patient's behavior disorder and may block
the possibility of his achieving a better life through giving up the
satisfaction of such needs. However, more rational treatment may be
impossible or may be refused, and the acuteness of the situation may
call for an immediate solution. The rational approach of helping the
patient to grow up requires sound judgment on the part of the therapist,
cooperation with the patient's family, and a wholesome therapeutic re-
lationship with the patient himself. Also, the patient and the therapist
must be willing and able to spend the necessary time and effort. Given
these requirements, treatment can be rewarding and successful.

What preventive measures might be taken to reduce the extent of
dependency?

Abnormal dependency in adult life may be prevented by helping
a child to learn gradually to assume responsibility and an independent
way of life. These measures should be taken from birth. In the early
years, the child depends upon his parents and should be allowed fully
to satisfy his need to be secure. Some anxiety is inevitable for biological
and for sociological reasons. However, in a loving, disciplined family the
child is usually able to build adequate defenses. The child needs growing
space so that he can become a person, uniquely aware of his capacity for
self-determination. He will show spontaneously his desires toward in-
dependence and if given the opportunity, will take responsibility and be
creative in terms of his ability at each stage in his growth. If parents are
able and willing gradually to give up their control of the child, he will
develop into normal adulthood. Unfortunately, some parents do not feel
sufficiently secure. They impose their own will upon the child by deny-
ing him room to grow. They become frightened if the child's behavior

threatens them, and they blame the child rather than support him in his problems. If serious dependence problems are recognized at any age level, counseling or psychotherapy from a psychiatrist, social worker, or psychologist may be indicated.

The process of becoming a more and more independent person is slow and gradual, and the child needs the parents' help and encouragement in this. Gradual growth in independence is a continuing process from birth through adulthood. A person who has grown up in this way is better prepared to face the changing dependence-independence ratios inevitable in old age.

DEPRESSIONS

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What is a depression?

A depression is a state of mind or, more specifically, a mental disorder characterized by a lowering of the individual's vitality, his mood, desires, hopes, aspirations, and of his self-esteem. It may range from no more than a mild feeling of tiredness and sadness to the most profound state of apathy with complete, psychotic disregard for reality.

What symptoms does a depressed person show? How does he feel?

At times the depressed individual is easy to recognize. His movements are slow, his posture not as erect as normally, and his face reveals dejection and tiredness. He has no appetite, he may be losing weight, and he may be suffering from constipation. He sleeps poorly, and often feels worse in the morning than toward evening. Initially he may still work, but ordinary tasks become burdensome and difficult. Finally, all but the most basic functions may cease.

He feels tired physically and mentally and his general attitude is one of an all-pervading pessimism. Neither can he believe that anyone might still care for him nor that his situation will ever change. Self-destruction will appear to him as the only possible solution, and the thought and later the impulse to take his own life may ultimately override all other considerations.

In contrast to patients with other mental disorders, the depressed patient is rarely confused. He realizes where he is and what date it is, although hours may seem like days and days like weeks. His thinking remains clear. He usually relates well to others, and is grateful for help, even though he may consider it futile.

Only when depression deepens severely will reality become distorted. The patient may then be delusional and hallucinated. Minor misdeeds of the past will suddenly be remembered as grave sins, and irrational guilt, fears of impending poverty, terrible physical illness, and death will plague him. He may hear accusatory and derogatory voices and the preparations for his execution.

Are there different types of depression?

Yes. Depression with its various manifestations can be the only symptom complex an individual may show and thus constitute a mental disorder in itself. Here we mention primarily the neurotic (reactive) depression, the more severe psychotic depressive reaction, the involutional depression or melancholia, and the depressive phase of the manic-depressive psychosis. However, depression can also precede or be part of other illnesses, such as schizophrenia, senile or arteriosclerotic brain disorder, and of serious metabolic diseases. Finally, we may find an element of depression as a constant component of an individual's basic personality. (See *Manic-Depressive Psychosis*)

Can depression be normal?

Anyone who experiences the loss of a beloved person, of fortune, or work can react to it with grief and depression. Although such a depression may show many of the symptoms described above, it is by definition self-limited in extent and time. The person thus afflicted overcomes his mourning period without much outside help and regains his balance and normal mood within a few weeks or months.

What is reactive or neurotic depression?

Both terms, *neurotic* and *reactive* depression, have the same meaning, namely that there is evidence of a more or less clearly definable cause for the depression. Yet the relationship between cause and symptom is not as obvious as in a normal grief reaction. The neurotic depression appears to be out of proportion to the cause invoked. Thus the depression must be understood as the reaction of an overly or neurotically sensitive person to an event with an emotionally specific and complex meaning. Usually these individuals have a history of other neurotic manifestations. Their depression can be seen as a defense mechanism against the emergence of painful and disturbing memories. In contrast to the neurotic individual, who projects his feelings of guilt and anxieties onto others, thus becoming suspicious or paranoid, the depressive neurotic introjects these feelings, i.e., in a masochistic fashion he accuses and punishes himself to an extent that remains incomprehensible until analysis uncovers the hidden psychological mechanism that has led from the original traumatic experience to the neurotic reorientation of the patient's personality and the reaction to the immediate cause of the depression. Thus the event that provokes this kind of depression may be one which in other individuals would merely lead to a normal reaction of grief, but due to its

very particular emotional charge, it actually triggers a reaction that appears to be out of proportion. Nevertheless, we can say that without the external event, such as the loss of a relative or another object of love, the depression would not have appeared.

At this point we must mention a distinction that is important not only to our specific subject, but to psychiatry in general. It is the distinction between "understanding" and "explaining."

An alcoholic in his delirium may hear voices accusing him of infidelity or homosexuality. Knowing his history and his personality we may well "understand" that he hears just that. This of course does not "explain" why he hallucinates in the first place. The "explanation" (for his delirium and hallucinations) is the intoxication of his brain with alcohol. In the neurotic depression a true understanding of the dynamic psychological mechanism underlying the depression also furnishes the explanation for it. However, in all other forms of depression this is not necessarily true at all. Psychotic depressive reactions, depressive phases of a manic-depressive psychosis, and involutional depressions often occur without any cause that could sufficiently explain time of onset, extent, and duration of the depression. Yet the ideas that the patient expresses and the content of his delusions can only be understood on the basis of his personality structure and life experience. For many psychiatric disorders, such as the one just mentioned, we do not as yet have scientifically valid explanations.

Reactive (neurotic) depressions often appear in the guise of vague physical complaints. Thus there are patients who wander from one physician's office to another, complaining of backaches, headaches, exhaustion, and the like, without getting relief from the symptomatic treatment offered. The depression is not recognized. Their pains are not faked or "hysterical"; they are due to the inner tension the depressed patient experiences. In some cases increased drinking may be the outstanding symptom of a neurotic depression. Here it usually constitutes an attempt to relieve tension and dispel sadness.

Do reactive depressions occur more often in certain groups or personality types?

Although there is good evidence that in the manic-depressive psychosis hereditary and constitutional factors play an important role, this does not seem to be the case in neurotic depression. Individuals who develop reactive depressions are often rather passive, insecure, and oversensitive individuals, unable or unwilling actively to retaliate against aggression or openly to express their anger.

Reactive depressions occur more frequently at times of internal and external stress and where major adaptations to new situations have to be made. Thus we find them proportionally more often in the elderly, where losses are naturally more frequent, and where the resistance to stress becomes weaker. Among the younger, we encounter reactive depressions more often in adolescents where the emotions frequently are unstable. Reactive depressions may be related to such recurrent events as menstruation and childbirth.

It is assumed that neuroses, in general, and thus also neurotic depressions, are encountered more frequently in persons with at least average or above-average intelligence than in those of below-average intelligence.

Being married seems to be a certain safeguard against some mental ills in some ways, and it also augurs favorably for those who have fallen ill. On the other hand, the unmarried woman, who approaches the age when opportunities for marriage become more unlikely, is not infrequently the prey of a reactive depression. There are, of course, other circumstances predisposing a person to a neurotic depression, such as crippling accidents and diseases, totally hopeless life situations, forced retirement, a decline in physical and mental health, and loss of skills.

Can reactive depressions develop into more serious mental disorders?

Neurotic depression, as we have defined it, is a specific emotional reaction to a certain stress and as such is usually limited in time and extent. However, we also observed that such a depression can be the precursor of another mental illness. It is entirely possible that a person, becoming aware of a slowly developing schizophrenic illness, or senile or arteriosclerotic brain disease, or of the growing of a brain tumor, develops a reactive depression which, for all practical purposes, may at first mask the more serious condition. However, sooner or later the underlying illness will dominate the clinical picture. Thus it would not be really correct to say that a reactive depression develops into a more serious mental disorder. It may merely indicate that something more serious is going on.

Is it possible to distinguish a neurotic depression from other forms of depression?

Usually this is possible. However, a first depression in an individual's life may pose a diagnostic problem. In general, we may say that in contrast to psychotic depressions, neurotic depressions are brought on by an observable saddening event, and do not assume psychotic di-

mensions, i.e., the individual retains good contact with reality, does not become delusional and hallucinated. He usually continues to work, can be cheered up at least temporarily, and does not suffer from the more serious physical symptoms of psychotic depressions, such as loss of appetite and weight, persistent constipation, and severe insomnia. However, if a depressed individual has had previous depressions, an attack of mania, or if he has suffered from marked mood swings throughout his life, we are more inclined to think of his depression as being a phase of a manic-depressive psychosis, regardless of the symptoms present. A first depression, during or near the involutional age, will most likely not be of a neurotic nature.

Can infants and children be in a state of depression? What is "anaclitic depression"?

Depression in children is not frequent but does exist, and may range from short-lasting depressive mood swings to deep depressive psychoses. Suicides and suicide attempts among children are rare but occur during puberty.

René Spitz from Austria made interesting observations on infants who were separated from their mothers and placed in cold and impersonal nurseries, communal homes, and the like. He noticed that unless these children would find some adequate, warm, and love-spending substitutes for their mothers, they would become depressed, uncommunicative, would stop eating, have frequent stools, lose weight, and wither away. This condition, which Spitz called "anaclitic depression," may end in the death of the infant. If it does not, it may in later years lead to an excessive need for attention and affection or, if such needs are rejected, to antisocial behavior.

What is involutional depression? How does it differ from other forms of depression?

Women, but to a certain extent also men, who approach and go through the years of involution, have to make a definite readjustment to life, physically as well as emotionally. This period can also be induced through X-ray treatment or surgical removal of the ovaries. The potential psychological complications are the same as in normal involution. These years for many are quite difficult, and in some, probably predisposed individuals, the adaptation fails. When this happens the individual may either react with suspicion and paranoid

delusions or with the so-called "involutional depression" or "melancholia." To the observer these patients appear much more agitated, loud, restless, and confused than do patients with other types of depression. Frequently they express rather bizarre delusions concerning the functions of their body. They may complain that their stomachs have rotted, the heart has stopped, and their bowels have disappeared. Hallucinations of pessimistic content and quite often an admixture of paranoid or persecutory ideas give the clinical picture a rather distinctive flavor. (See *The Senile Psychoses*)

Can reactive depression result in suicide?

Certainly. What determines the extent of suicidal ideas and impulses is the degree of guilt and hopelessness the patient experiences. As the depression deepens guilt feeling, pessimism, and hopelessness increase, regardless of the type of depression. However, since patients with neurotic depressions are usually aware of their conflicts, frequently seek and accept help early, they can more readily be prevented from actually committing suicide.

In this connection it is important to know that the risk of suicide is not greatest at the height of depression, but rather when the patient emerges from it. It is believed that the patient's physical energy returns first, while his thoughts still remain thoroughly pessimistic and guilt laden. Thus the patient at this time is more prone to act than when he is in a state of utter physical and mental inertia. For practical purposes the physician must always consider and assess the possibility of suicide in any depressed patient. (See *Suicide*)

How long do reactive depressions generally last? Are they likely to return?

It is difficult to predict the length of any depression. Even the most severe psychotic depression almost invariably clears up spontaneously after several months or a year. Although chronic depression does exist, it is nevertheless an infrequent condition. Neurotic depression rarely lasts more than six months. From everything we have said about the neurotic depression it is obvious that, at least theoretically, this type of depression can recur. However, this is infrequent and if we are confronted with recurrent depressions, we are more inclined to diagnose it as a manic-depressive psychosis.

What are postpartum blues?

Immediately after childbirth some women become depressed. The sudden release of fear and tension that may have existed prior to delivery, the physical exhaustion from labor itself, and the possible existence of emotional resistance against the newborn child may all contribute to such a depression. This condition may last only a few days or develop into a more serious postpartum psychosis demanding immediate psychiatric attention. The term "postpartum blues" is really not a psychiatric term; what it implies is a mixture of reactive depression and of what has been described as depression due to physical exhaustion.

What is alcoholic depression?

This, too, is neither a psychiatric term nor entity. A good number of alcoholics make honest attempts not to drink. Yet so frequently they fail and get drunk. Upon awakening they may then experience feelings of depression that are a mélange of disgust, hopelessness, self-pity, and physical malaise.

What are retarded and agitated depressions?

These terms are descriptive but not diagnostic. "Retarded" indicates that the patient is inactive, passive, and brooding. A depression is called "agitated" when the patient expresses his fears by loud complaints, crying, constant pacing, and hand wringing. Any depression may assume either form, depending on the patient's basic personality. However, as we mentioned before, the involutional depression is more often of the agitated type.

What is a delayed depression?

Not infrequently we hear of a person who at the time of loss of a parent or child did not show any signs of emotion. Yet, suddenly, days or weeks later, this same individual may show all the symptoms of grief or depression. What has happened?

As mentioned previously, the object, the loss of which leads to a reactive depression, has a very complex meaning for the neurotic individual who experiences the loss. Thus a daughter may deeply love her father but at the same time hate him for various reasons. Both love and hate may be vehemently denied and a strong emotional struggle, usually quite unconscious, may result. The daughter feels

guilty for loving and for hating the father, and after his death will increasingly identify with him, finally symbolically incorporating him within herself. The guilt feelings together with the need for punishing the father, i.e., now for self-punishment, are believed to be the psychological roots of the neurotic depression.

When the loss actually occurs, i.e., when the father thus loved and hated dies, the daughter may first react with a complete denial of her emotional involvement. Neither tears nor satisfaction are permitted to show. Yet when the identification with, and the introjection of, the father image are complete the daughter may safely show emotions now devoid of obvious ambivalence, altogether turned against herself: she becomes depressed. This may be called a "delayed depression."

> *Why in certain stress situations such as in concentration camps or war do individuals not respond with depression?*

We pointed out that the neurotically depressed person reacts with depression to a conflict within himself, especially a conflict marked by strong emotional ambivalence toward the lost person and overwhelming feelings of guilt. All the destructive tendencies inherent in depression are directed against the depressed person himself who consequently has a low opinion of himself and a high opinion of all other people. War, and much more so concentration camps, mobilize entirely different feelings and motives. Here the inmate's hostility is constantly aroused against his persecutors, his pride is hurt by sources outside himself, he is being punished for something he does not feel guilty of, and his ego and his morale are thus actually strengthened instead of being weakened. What prevents him from surrendering and thus also from getting depressed is his open or hidden attitude of rebellion and hope of ultimate victory and revenge. Tragically, many of these people entertain vivid fantasies of what life will be like once liberation has come, and for some the sobering aspect of reality after liberation proves to be too much to endure. Hope fades, and with the external pressure gone, they become depressed.

> *Are there signs that indicate oncoming depression? If so, can the depression be prevented or reduced?*

For the patient himself, the earliest signs of an oncoming depression are usually a decrease of the accustomed enthusiasm for, and

interest in, his work, the lowered speed with which he goes about his business, and an increase of difficulties he encounters in his usual daily chores. Other frequent warning signals are poor sleep, bad dreams, waking up tired in the morning, and loss of appetite. In other cases, headaches, backaches, or general malaise may be such fore-runners.

It is certainly most important to become aware of a person's depression as early as possible. This is quite clear if we think of the danger of suicide. In the case of neurotic depression, psychotherapy or drug therapy may well avert the development of a deeper depression. This, however, is not always the case and often a depression takes its "normal" course, so to speak, in spite of all our efforts. (See *Psycho-therapy*)

Are there psychological tests that reveal depression in general and reactive depression in particular?

A number of psychological tests are very sensitive in reflecting the presence of depression. One of them is the Rorschach, an inkblot test that consists of the free interpretation of indefinite black and colored inkblots. In this test a depressed person will usually give comparatively few answers, will respond more readily to the black than to the colored cards, and the answers themselves will betray the subject's pessimism and his heightened critical attitude. For instance, the interpretation of a "dead butterfly" instead of a "live" one, of a "crumbling castle" instead of a "beautiful" or "proud" one, or of "heavy clouds" would be quite indicative of depression. Other tests, such as the Thematic Apperception Test, where definite pictures are interpreted, or the Minnesota Multiphasic Personality Inventory, also give rather decisive indications of the presence of depression. The clear evidence of certain specific emotional conflicts as shown in the test protocols can corroborate the clinical diagnosis of a neurotic depression.

What can help to relieve or to terminate depression?

With the steady increase in knowledge concerning nature and types of depression and in available therapeutic measures, treatment during the past few decades has become much more refined. We cannot say that "depression" will best be healed with such and such therapeutic measure. We must carefully evaluate who the depressed

person is, under what circumstances he became depressed, and of what type and magnitude his depression is. Neurotic depressions must be handled in one way, psychotic depressions in another, and agitated depressions need a still different approach than retarded forms.

Let us consider a few general therapeutic measures. First, a change of environment, where it is possible, will frequently be beneficial. To remove the patient from the place where he became ill—from a depressing environment or from an overwhelming family situation—may break a vicious circle of ruminations, or a need for unconscious demonstrations of illness in front of husband or children, and may support emerging tendencies to repair. This is particularly true for the reactively depressed. The patient with a psychotic depression should always be hospitalized because of the danger of suicide. Second, work, or another sort of activity, is good for the depressed patient. It will diminish the tendency toward self-accusatory rumination and give the patient a feeling of satisfaction and pride at the end of the day. However, the amount of work to be prescribed must be carefully weighed. If too much is demanded of the patient he will not be able to handle the task, and this, for him, will justify the poor image he has of himself. Consequently he may well become more depressed. Therefore, the amount of work expected of him must always be slightly below what one estimates to be his performance level at the particular time.

Trying to make a depressed person participate in festive events may have a rather adverse effect. The depression inhibits all feelings for happiness, and seeing others dance and enjoy themselves only reminds the depressed individual that for him this is forever impossible. A good friend and valuable therapeutic aid to the depressed patient is a generous amount of sound sleep. The sleepless and tormenting nights are dreaded by all depressed persons. Sleep will give them respite and peace. Not too long ago, it was quite customary to treat depressions by giving opium over a prolonged period of time with the purpose of removing the patient, so to speak, from his worries, fears, and self-accusations. This is not done any more; we now have more specific drugs at our disposition; however, a sufficiently strong sedative at night should be part of the treatment.

How shall we, as relatives, friends, or physicians, approach the depressed patient? In speaking to himself the patient has very few friendly words. He is harsh and derogatory to himself. If we talk

to him, we should neither imitate this altogether nor should we do the opposite, because the patient would doubt our sincerity. We must convince him that we have warm and serious feelings of understanding and acceptance for him, that we will be reliable in our support but also firm in our attitude. We must be neither overbearing nor cool and aloof. We must attend to his needs, but not to his fancies; we must be with him when he needs us, but we must be willing to leave him alone when he desires this and if we are sure that it is safe.

How successful have drugs been in relieving the different kinds of depressions?

There are several types of drugs capable of relieving certain forms of depression. Drugs containing Dexedrine usually have no lasting effect, produce undesirable side reactions, and in addition, are habit forming. They are rarely used. These, as well as all other drugs for depression, should only be prescribed by a physician. So called "pep-pills" often contain Dexedrine or caffeine. Since 1953 a number of drugs with much more specific antidepressant effects have become available. Some of them are presently used with good results in carefully selected cases. They are hardly ever effective immediately, the first signs of improvement appearing usually in the second or third week of treatment. This eliminates them where immediate action (danger of suicide, etc.) is needed. Reactive depressions usually respond well to some of these drugs. Psychotic depression and particularly depression of involution react less favorably to drugs, although considerable improvement can often be obtained. In all cases it has proved to be important not to discontinue the drug as soon as the patient has improved or even recovered, but to continue medication for a certain length of time. This often prevents the return of the depression.

What are other methods of treatment for depression?

For the last two decades various forms of "shock treatment" have been used to relieve depression. These consist in the artificial production of a general convulsion which in almost all aspects resembles an epileptic seizure. Today the electrically induced seizure is the one most widely used. Since antidepressant drugs have become available electroshock therapy has been used less often and in some places it has been abandoned almost entirely. However, interest in this method

is again increasing and there is good reason for this. In spite of some of the unpleasant aspects, dangers, and side reactions, electroshock therapy has undoubtedly the most rapid and decisive effect on all forms of psychotic depression. It will hardly be used in the mild forms of reactive depression but even there it can be considered. It is not unusual at all to see a deeply depressed patient emerge from his apathy and regain his normal mood after two or three treatments. Electroshock therapy must be considered as the treatment of choice whenever the patient's life is endangered, be it through suicide, refusal to eat, or extreme loss of weight. It must also be considered when prolonged hospitalization or ambulatory treatment is not possible for financial or other reasons.

With modern techniques the dangers of electroshock therapy are minimal, even when compared with those encountered in the treatment with antidepressant drugs.

Insulin shock therapy has no practical value in the treatment of depression. It is a slow, cumbersome, and expensive procedure, usually extending over a period of several months. Occasionally a chronic depression, resistive to all other modes of treatment might respond to it. The value of psychotherapy in depression has been much discussed, and the opinions of the experts are divided. Undoubtedly, psychotherapy is the treatment of choice for the neurotic depression, alone or in combination with antidepressant drugs. Since by definition the neurotic depression has as its cause a psychological conflict, psychotherapy, by solving the conflict, should, or at least can, have a curative effect. Many psychiatrists, and primarily psychoanalysts, feel that psychotic depressions and depressions that are part of a manic-depressive psychosis, also have psychological conflicts as causative agents and they advocate that psychotherapy, beginning after the acute phase of the depression, will effect a permanent cure. This claim is difficult to prove or to refute, since the recurrence of depression can never be predicted with certainty. To this writer it appears that the question of whether or not psychotherapy is needed must be evaluated individually for each patient.

What has been the success of any of these methods?

When the physician assures his depressed patient that he will get well, he moves on fairly safe ground. Even without any treatment most depressions will eventually lift. However, whether or not "eventually" means a few days or a few years is often difficult to predict.

This is one reason why the results of treatment are not easy to assess. Nevertheless, there is agreement among the experts that electroshock therapy as well as drug therapy are highly effective in quickly relieving or in essentially shortening depression. However, once discontinued, neither therapy can prevent the recurrence of a depression.

From large statistical data we learn that up to 90 per cent and even 100 per cent of all psychotic depressions recover after electroshock therapy. Similar results are obtained in involutional depressions. Comparative figures from treatment with drugs are definitely less favorable. Of patients with psychotic depressions, about 40 per cent improve moderately to markedly, and of those with involutional depressions 50 per cent, when treated with antidepressant drugs. Patients with neurotic depressions recover invariably regardless of whether treated with drugs or electroshock therapy. Old age does not exclude effective treatment of depression. Even the patient with senile or arteriosclerotic brain disease who develops a depression can respond extremely well to electroshock therapy and thus regain some happiness.

ALBERT DEUTSCH —
CRUSADER, 1905–1961

by JULIUS SCHREIBER, M.D.
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This biographical sketch of Albert Deutsch, written by his
very close friend, Julius Schreiber, includes portions of the
eulogy that Dr. Schreiber delivered at the funeral of Albert
Deutsch in New York City on June 25, 1961.

How does one sing the praises of a man whose adult life was so packed with one meritorious act after another—whose feelings, thoughts, and actions were synonymous with all that is noble in human aspiration and heroic in human deed?

No one person can fully sing his praises. All of us who knew Albert Deutsch—all of us who were enriched by the privilege of being with him, listening to him, laughing with him, talking with him, working with him, playing with him—all that we can do is stand back in awesome reflection and meditation.

Some will say, "How can Albert—the man who inspired me to face the reality of man's inhumanity to man and who pricked my conscience so that I took positive actions—how can he be gone? He is still with me because he is part of me!"

Others will say, "How strange—how strange that we doctors, we psychiatrists, who are charged with the responsibility of looking after the mentally ill, should have needed the example and inspiration of Albert Deutsch—how strange that this man, this so knowledgeable and forceful and dedicated a personality, more than anyone else in all of America, should have come from outside our profession and moved among us and deeply into us and galvanized us to rededicate ourselves, to examine and re-examine the quality of our care and treatment of the mentally ill."

How strange and yet how wonderful! He saw the neglect and overcrowding, and he disliked what he saw, and he thundered about it.

Shout he could, and he did. Yet Al was gentle and so very loving and kind—the children as well as the grown-ups basked in the

warmth and light of his personality. And Al was also powerful and vigorous. He loved humanity, loved it so much that he fought with ardor and fury against all unfairness. He resented tyranny and struck out forcibly against it, whether it was tyranny over the mind or over the body.

Every man, woman, and child, Al believed, deserves a chance for a full and meaningful life. Everyone: Negro and white—Jew, Christian, Muslim, Buddhist, Confucian—atheist, agnostic, and theist—foreign- and native-born—the sick and the well—*all* have a right to a chance for fulfillment. And Albert devoted his life to see that they had that chance. He believed passionately in the teachings of his ancient forebears:

Veh-o-hahvto L'roh-echo K'moh-cho: Thou shalt love thy neighbor as thyself!

This was our man, our friend, our Albert. And he did move among us and did become a part of us. Albert Deutsch cannot be gone, because we are here and we are a part of him and he is part of us!

This was indeed a remarkable, noteworthy man. Where did he come from?

He was born in New York City on October 23, 1905. He grew up in that massive concentration of humanity—playing and fighting and pushing and squeezing his way through the crowded streets and chapters of his youth. An accident cost him an eye at the age of five. But that's the way it was—one lived and fought on the street where the big guys knocked down the little guys, where pranks played upon others provided inexpensive fun for the mischief-makers and occasional anguish for the victim. The playmates of his youth had their destinies to fulfill. Some reached their unplanned ends when they entered state or federal penitentiaries. Others proved that man does have the capacity to alter, in some measure, his fate—that the poverty and sickness and greed of the social jungle need not succeed in distorting and crushing the human spirit. Albert Deutsch proved this in a most remarkable way.

How did it happen that this nameless and faceless boy of the crowd became the man of great knowledge and wisdom, of great courage and integrity, of warmth and compassion, of tireless energies in dedicated devotion to causes he championed?

There are no simple answers. We know that since age eight he made the New York Public Library his second home, reading avidly and remembering well what he read. We know that he rebelled at an early age against brutality and injustice and exploitation. We know that among the models and heroes of his early youth and adolescence were Thomas Jefferson, Thomas Paine, Abraham Lincoln, Voltaire, Pëtr Kropotkin, Fëdor Dostoevski, Lev N. Tolstoi, Henry David Thoreau, Ralph Waldo Emerson, Robert G. Ingersoll, Walt Whitman, Thorstein Veblen, Lincoln Steffens, and George Bernard Shaw.

Unlike some of his adolescent peers, his working models were men of humanitarian ideals rather than gangsters with fast guns. One can only guess at the innumerable factors that molded his youth and directed his course, but Albert Deutsch walked *up* the one road rather than *down* the other. He turned *to*, rather than *against*, his fellowman. He became a man of concern, of care, of love for mankind—and he translated his knowledge, his values, and his feelings into courageous, consistent action.

After leaving high school in the middle of his senior year, he tried his hand at a number of odd jobs: a common laborer in an iron foundry, a stevedore in New Orleans, a drydock worker in California, an extra in the movies, a spear carrier in an opera, and an eight-month sojourn on the stage playing the role of the priest in *Cyrano de Bergerac*, working with the Walter Hampden troupe.

In 1928 he did his first professional writing, preparing ancient history articles for an encyclopedia for children. After two years of this, he spent the next two years writing similar articles for an encyclopedia for adults.

In 1932 he began a nine-year period with the New York State Department of Social Welfare. During these years, the fires of his concern for the welfare of his fellowman burst into flames, casting ever-widening circles of light and heat. For Albert Deutsch was not a cool, dispassionate man. He scanned the social horizons of New York—his state—of the United States—his country—and of the world—his home. He saw much that was good and much more that needed repair or outright change. Why, he asked, all this poverty in the midst of abundance? Why, with modern medical knowledge, so much untreated sickness? Why the fear, the hate, the confusion, the anxiety, the increasing numbers of mentally ill—and why their

neglect? This last, the neglect in the care and the treatment of the mentally ill, was particularly plaguing and angering.

Under a grant from the American Foundation for Mental Hygiene, he wrote his classic work, *The Mentally Ill in America.* Published in 1937, this history of the care and treatment of the mentally ill from the earliest colonial days to modern times was hailed at once as a colossal beacon light casting revealing rays of information about the past to better guide the efforts of the present and the future.

Beginning in 1941, the pages of the New York newspaper *PM* (now defunct) carried a daily column by Albert Deutsch dealing with one or another phase of human welfare. All social ills attracted his vigorous attention. As the months and years rolled on, his knowledge and influence grew. Were two or more families living in space designed for one? Get Albert Deutsch to write about over-crowded and inadequate housing! Was there corruption in local, state, or national government? Get Deutsch to tackle the hypocrisy and crime of some of our officials! Were there fraudulent healing claims and fake cures by medical quacks? Get Albert to expose them in his newspaper and magazine articles! Was the medical care in our veterans hospitals inadequate or poor? Tell Deutsch, and he will get the facts to the public! And so it went—exposing and fighting poor housing, police corruption, reformatories that did not reform, inadequate medical care. But, always, his major attention was focused on the needs of the mentally ill—the hapless brothers and sisters of the human race who were dumped into "asylums," and too often neglected and forgotten.

In 1946 the National Committee for Mental Hygiene, in award-ing him a special citation, stated: "No newspaper writer is more clearly identified with the field of mental hygiene than is Albert Deutsch." That same year he received special citations from the American Newspaper Guild's Heywood Broun Award Committee for his articles on mental hospitals, just as he had received similar citations a year previously for his articles on veterans hospitals. In 1947 the New York Newspaper Guild honored him as "the most distinguished and effective humanitarian crusading in American journalism."

A decade after the appearance of his book on the mentally ill, he made a special tour of mental hospitals in all sections of the

country gathering a mountain of evidence, most of it damning, and quite disturbing to the conscience of those who would but see.

In 1948 he wrote another book, *The Shame of the States*. In this volume he crystallized his mental hospital findings and challenged state and national leaders to do something constructive about them. The overwhelmingly favorable response to his clarion call is now history.

In 1949 he won the Lasker Press Award for "public information leading to public action in the field of mental health." That same year he received the Polk Memorial Award for outstanding journalism in the field of public welfare. In 1953 he received the Adolph Meyer Memorial Award for his work in improving the conditions in our mental hospitals. In 1958 he was singularly honored—and the first journalist ever to receive this significant honor—when he was elected an Honorary Fellow of the American Psychiatric Association.

Amidst all his other activities, Deutsch found time to write, in 1950, *Our Rejected Children*, dealing with the problems of juvenile delinquency; and in 1955, *The Trouble with Cops*, a critical survey of law enforcement problems in the United States. He also coauthored *A History of Public Welfare in New York State* (1941), and edited in 1948, *Sex Habits of American Men*, a symposium of expert evaluations of the first Kinsey Report.

Congressional committees dealing with various medical and social problems frequently invited him to present his views for their consideration and guidance. He testified before such committees on a number of problems, including: veterans hospitals, juvenile delinquency, and the care and treatment of the mentally ill. On March 28, 1961, less than three months before his death, he again testified on Capitol Hill, this time before the U.S. Senate Subcommittee on the Constitutional Rights of the Mentally Ill. Eloquent evidence of the fires burning within him is given by the following portions of his testimony:

> I share with many of my fellow citizens a deep sense of gratification that this splendid subcommittee is now turning a powerful searchlight on one of the darkest and most shameful areas of public neglect. As historian, journalist, and citizen, I have been actively interested in the plight of the institutionalized mentally sick for a quarter century. With many others, I have been picking at the

public conscience in their behalf, relying mainly on medical, economic, moral, and humanitarian persuasion. Now, by a paradox of progress that I'll define later, a new and, I trust, more effective instrument of reform comes to hand—the demand for constitutional protection, for basic justice guaranteed to every American citizen not as a matter of mere charity or sympathy, but of inalienable right. . . .

None can doubt the impressive progress made during the past decade or so in the institutional care and treatment of the mentally ill. But neither can the sober student doubt that the rate of progress has been grossly exaggerated in many reports that reach the public eye and ear or that overoptimistic appraisals have tended to lull the interested public into a false complacency about present conditions.

The melancholy fact is that, in spite of recent progress, these conditions remain for the most part a disgrace to any civilized society, more so to a society that boasts a special concern for the civil liberties of the individual citizen.

About a dozen years ago I conducted a nationwide survey of mental hospital conditions in the United States. I reported my findings in a book, *The Shame of the States*. Some physicians I interviewed frankly admitted that the animals of nearby piggeries were better housed, fed, and treated than many of the patients on their wards. I saw hundreds of sick people shackled, strapped, straitjacketed, and bound to their beds. I saw mental patients forced to eat meals with their hands because there were not enough spoons and other tableware to go around—not because they couldn't be trusted to eat like humans. I saw them crawl into beds jammed together, in dormitories filled to twice or three times their normal capacity. I saw them incarcerated in "seclusion rooms"— solitary isolation cells, really—for weeks and months at a time. I saw signs of medical neglect with curable patients sinking into hopeless chronicity. I found evidence of physical brutality, but these paled into insignificance when compared with excruciating suffering stemming from prolonged, enforced idleness, herdlike crowding, lack of privacy, depersonalization, and the overall atmosphere of neglect. The fault lay not with individual physicians, nurses, or attendants—underpaid, undervalued, and overworked as they were—but with the general community that not only tolerated but enforced these subhuman conditions through financial penury, ignorance, fear, and indifference.

Conditions, as I noted earlier, have improved considerably since then. The advent of the tranquilizing drugs a few years ago reduced tremendously the resort to straitjackets and other mechanical restraints, which our British cousins proved unnecessary in the first place, more than a century ago. The "disturbed wards" are not the bedlams they were a decade ago. The application of the "therapeutic community" concept in a few hospitals—where patients, instead of being herded like animals and reduced to subhuman status, are given greater measures of freedom, participation, and responsibility—has tended to transform asylums to hospitals where it is adopted. So have other therapeutic devices. But these improvements, heartening though they be, must be measured soberly against the primitive level they proceeded from, the great distance we remain from achievable goals, and the continuing injustices and deprivations still inflicted on hundreds of thousands of our fellow citizens. . . .

In olden times we burned, hanged, and tortured mentally sick persons because we believed they were witches or possessed of demons. Then we imprisoned them because we regarded them as sinful or as criminals.

Later still we confined them because we didn't know what else to do. The plea of ignorance is no longer open to us as an excuse of needlessly depriving mentally sick people of sacred rights. We know what can be done, what is being done. I am not advocating that all the so-called insane be loosed on the community. But I am convinced that all but a very small proportion of the civil insane need not be subjected to degrading commitment proceedings and then locked up in custodial institutions. We can no longer tolerate the paradox of depriving mental patients of their civil rights in the name of hospital treatment when we know that it is not only unnecessary for security but harmful to potential recovery.

I feel strongly that every day we tolerate the needless confinement of a mental patient in a locked ward is a day of ignominy for all of us, a day in which we passively participate in a social crime against individual liberty. . . .

During the past several years, in addition to the free-lance writing of numerous magazine articles, Albert Deutsch was working (under grants from the National Association for Mental Health and later from the National Institute of Mental Health) on a survey of current research in the causes and treatment of mental illness. This most fundamental study carried him all over the United

States. He visited more than one hundred psychiatric training hospitals, clinics, and research centers where he not only made on-the-spot personal observations but also conducted lengthy and frank interviews with many of the nation's top professionals in the behavioral sciences: psychiatrists, psychologists, biologists, anthropologists, sociologists, neurophysiologists, biochemists, psychopharmacologists, geneticists, and others. By the summer of 1961, after five years of work, he had amassed monumental and extremely valuable information. These findings were to have been published in a book tentatively titled, *The Quest for Mental Health*. The final writing of this book was hardly begun when he died of a heart attack in his sleep, June 18, 1961, in Horsham, England, where he had been participating in a conference of the World Federation for Mental Health.

This man, who knew so much about the problems of the mentally ill and who knew well so many of the people who are professionally involved in the research, treatment, and prevention of mental illness, had the remarkable gift of being able to earn the respect and serious attention of all the outstanding leaders in the fields of the social and behavioral sciences. Though leaders of different and often conflicting "schools of thought" might have disagreed with each other, they all held Albert Deutsch in their highest esteem. From the Atlantic to the Pacific his name could spark excited interest in whatever he had to say.

When Franklin Watts sought the one person in all of America who was best qualified to be the editor in chief of *The Encyclopedia of Mental Health*, the only man who repeatedly was recommended in all professional mental health quarters was Albert Deutsch. For it was Albert Deutsch who commanded the respect of all the groups in the mental health movement; it would be Albert Deutsch who could bring together the most outstanding professional people to serve as consultants and contributors to this encyclopedia; it would be Albert Deutsch who could do the best job in planning and establishing the structure, scope, and ideals for the encyclopedia.

Because he believed deeply that *The Encyclopedia of Mental Health* was needed and could make a truly fundamental contribution, Albert Deutsch, in August, 1960, became the first and only editor in chief of *The Encyclopedia of Mental Health*.

Ten months later Albert Deutsch, at the peak of his vigorous and

productive life, was suddenly gone. And the world of mental health reverberated as the shocking news spread throughout the United States, Canada, and Europe.

Although the physical Albert Deutsch was gone, the spiritual Albert Deutsch—the symbol of the highest ideals of man's love and concern for his fellowman—would always remain. Within three weeks after his death, a group of his friends from different sections of the country met in Washington, D.C. They gathered not only to honor the memory of their beloved friend, but also to explore and implement the best means for advancing the things that Albert Deutsch believed in and struggled to achieve. And they knew they would also counsel, and later collaborate, with his hosts of other friends. Thus was created the Albert Deutsch Memorial Foundation.

The officers and board of trustees of the Albert Deutsch Memorial Foundation are leading figures in many of the fields that were of such vital concern in the life and work of Albert Deutsch: psychiatry, psychology, neurophysiology, social work, journalism, advertising, medical publishing, law, criminology and corrections, child psychiatry, and medical care.

The officers and board of trustees include: from the San Francisco area—Norman Reider, M.D., Mrs. Pearl E. Simburg; from Topeka, Kansas—Karl A. Menninger, M.D., William C. Menninger, M.D.; from Washington, D.C.—Judge David L. Bazelon, David G. Bress, Robert H. Felix, M.D., Seymour S. Kety, M.D., Julius Schreiber, M.D., David Shakow, Ph.D., I. F. Stone; from New York—Viola W. Bernard, M.D., Marion E. Kenworthy, M.D., Arthur J. Rosenthal, Charles Schlaifer, George S. Stevenson, M.D.; from the Boston area—Dean Charles I. Schottland (Brandeis University).

The Foundation plans to publish a memorial volume containing selected writings of Albert Deutsch together with excerpts of tributes paid to him during his lifetime and after his death. To encourage young science writers to follow in his footsteps, the Foundation has also created fellowships at outstanding psychiatric training centers, where promising young journalists will receive not only intimate and authoritative information on the facts of mental health and mental illness, but also a deeper awareness of the theories and methods of the behavioral sciences. In addition, there has been established an annual Albert Deutsch Award for signifi-

cant journalism in the field of mental health or social welfare, and also an annual *Albert Deutsch Memorial Lecture.*

It is no coincidence that some members of the board of trustees of the Albert Deutsch Memorial Foundation are among the consultants and contributors to *The Encyclopedia of Mental Health.* Nor is it surprising that the consultants and contributors to this encyclopedia are among the most ardent supporters of the Albert Deutsch Memorial Foundation, for a large proportion of them were personal and admiring friends of Albert Deutsch. What each of this group undertook to write, at Albert's invitation, as a matter of professional interest, became, upon Albert's death, also a personal expression of deep dedication to his memory and worth.

The worth and meaning, then, of Albert Deutsch continues and *will* continue in the persistent dedication to the cause of mental health, not only by all of us who were fortunate enough to know him and work with him, but also by everyone touched by the same dream for mankind, by the same conviction: *I am my brother's keeper and all men are my brothers!*

DIVORCE, EMOTIONAL PROBLEMS OF

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What is the definition of divorce?

There are essentially two forms of divorce: (1) an absolute legal dissolution of the marriage bond; (2) a judicial separation of man and wife, or termination of cohabitation, without dissolution of the marriage bond (limited divorce or divorce from bed and board).

How many people are in this group in the United States?

The Census reports for 1960 2,814,000 divorced persons in the United States: 1,106,000 men; 1,708,000 women.

Estimated national total of divorces and annulments granted in 1959 was 395,000. This represents an increase of 7.3 per cent over the 1958 figure of 368,000.

Do these statistics differ from those in other countries?

The report of the British Royal Commission on Marriage and Divorce (1955) gives figures on divorces per thousand of the population for 1950 as follows:

New Zealand and Australia	.86
Sweden	1.19
Denmark	1.55
United States	2.48

Are these statistics changing?

The number of divorces granted in a single year reached an all-time high in 1946, immediately after World War II, of 610,000. It decreased annually after that year until 1951. Since 1951, the rate has been relatively stable ranging from about 370,000 to 396,000. Although the divorce rate is fluctuating slightly from one year to the next, it is clear that the divorce trend is still upward.

Does our cultural and psychological climate induce divorce?

Marriage is today, as it has always been, part of the social fabric, and its structure, strengths, weaknesses, and values arise out of the particular cultural and psychological climate in which we live. In a society, or group, where divorce carries little social sanction or moral stigma, it seems probable that, given conditions of unhappiness and tension, the possibility of divorce as a solution will arise in the individual's thinking more quickly than were divorce still regarded as it was in our own country fifty years ago.

Does the cost affect the rate of divorce in lower income groups?

The cost of divorce undoubtedly affects the rate of divorce in lower income groups. This does not, however, offer a true picture of the amount of family disorganization or marital disharmony existing within this group. In many instances where cost is prohibitive and there is a desire on the part of one or both parties to escape the unhappiness of the marital bond, either separation by mutual agreement or desertion by one partner takes place. Permanent desertion has been characterized as "the poor man's divorce." Deserted wives (and wives are more often deserted than husbands) frequently are handicapped both by lack of legal knowledge and by the lack of financial means for obtaining a divorce. In consequence, we have no way of knowing the extent of desertion, whereas divorce statistics are available for most states and for the country as a whole.

What are the main legal reasons given for divorce today?

It is a well-known fact that the legal reasons given for divorce in the United States often bear little resemblance to the marital problems involved, but represent the conditions under which divorce is obtainable within the particular governmental jurisdiction. In general, the rule in such suits is that the legally most effective and morally least accusatory grounds are asserted in the suit. The United States has a very

confusing system of divorce legislation. Until 1949, South Carolina did not allow divorce on any grounds. Legal terms are often defined differently in various states, a good example being "desertion." Some of the more familiar charges for divorce are desertion, adultery, bigamy, cruelty, habitual drunkenness, nonsupport, fraud, and duress. Impotence and insanity at the time of marriage are also grounds in some states.

What are other reasons for divorce in the United States?

Marriage today, as contrasted with marriage some fifty years ago, has as its primary values mutual love and affection, including sexual satisfaction, equality of the partners, and freedom for personal development. Anything that disturbs the mutual sympathy and love between husband and wife creates serious tension when marriage is based on a presumption that it must offer individual happiness. If happiness is not attained, the marriage is regarded as a failure. Since marriage for love has become the basic pattern in our country, unhappiness in marriage is often blamed on a faulty choice of mate, rather than on a faulty adjustment between the two partners. Divorce or separation, with choice of another partner, may be seen as a possible solution. Essentially, marriage is a vulnerable human relationship composed of the feelings, attitudes, values, behaviors, and demands that flow back and forth between the partners. Each acts as both cause and effect within this relationship. The difficulty that disrupts the relationship lies in a destructive interaction between the two partners. The focus of their difficulty may be a mother-in-law, sexual incompatibility, money, etc., but the basic problem is the failure of each to meet the other's emotional needs to a satisfactory degree.

Is the woman likely to be the one to desire divorce first?

It is difficult to get conclusive evidence on this question. William J. Goode, in his book, *After Divorce*, found that 62 per cent of the women stated that they first suggested the divorce, 13 per cent stated it was mutual, and 25 per cent said it was the husband who wanted it first.

William Goode felt, however, that it was more often the husband than the wife who first wished to terminate the marriage. This would agree with the prevalent theory that the wife has a greater social and emotional investment in the marriage and would, as a consequence, be more concerned about preserving family ties.

Are there certain groups which show higher divorce rate than others?

Yes, there are. Because information on religion is difficult to obtain, no question regarding religious affiliation has been listed on the decennial census, nor, with one exception, have any of the states or territories ever included the question on the marriage or divorce records.

Catholics, because of their doctrinal opposition to divorce, are underrepresented in the divorced group.

Jews are generally reported to have a lower percentage of divorce than their representation in the population.

Studies of divorce records indicate that upper occupational groups are underrepresented, middle occupational groups are proportionately represented, and the lower groups are overrepresented in the divorced population. However, a study of 4,500 divorce cases in Iowa found that farmers had the lowest divorce rate:

Farmers	1.5
Professional—proprietors	3.4
Clerical	4.5
Salesmen	6.9
Skilled	7.8
Semiskilled	8.3
Labor—service	18.7

For marriages which ultimately end in divorce, the breakup, actual and legal, is most likely to occur in the one- or two-year period immediately following marriage, the disruption percentage showing a subsequent yearly decline from that time on.

Does divorce tend to run in families?

Marital discord and divorce tend to run in a family. For example, in about two-fifths of the 1,422 divorces granted in the Toledo Family Court in 1953, one or both partners, or members of their immediate families, had been parties previously to one or another form of matrimonial action.

Is a marriage that has produced children as prone to divorce as one that has not?

William Goode thinks: "For the married population as a whole, the childless couples are about twice as prone to divorce, but

most analysts feel that the same factors that lead to postponing children also lead to divorce. That is, the decision to have children is for many a decision that the marriage is good enough to continue; or, negatively, since the marriage is not going well, there should not be any children just yet."

Is the divorce rate among second marriages higher than first marriages? What might this indicate?

According to Jessie Bernard, in *Remarriage,* the divorce ratio increases with each subsequent divorce, that is, partners once divorced are more likely to divorce again than those never divorced. Any marriage requires adjustments, and for the remarried there may be many more complicating factors. In addition to the kinds of conflicts that may arise in any family, Jessie Bernard lists the following issues likely to split families of remarriage: (1) competition, (2) mutually incompatible values, standards, role conceptions, or principles, (3) money or property.

Is the young marriage as likely to end in divorce as one where the participants are in their middle or late twenties?

There is a close relationship between early marriage and instability of marriage. This is especially true of those who marry below the age of twenty-two. The proportion of divorced and remarried women, according to the United States Census, among those who first married below the age of eighteen, was about three times as high as that for women who first married between the ages of twenty-two and twenty-four years.

Does the fact that divorce laws are becoming more lenient have an effect on the divorce rate?

The fact that divorce laws are more lenient may have some slight bearing on the trend, but marriage and divorce are part of a very complicated and changing cultural pattern. The functions and expectations of marriage are changing, calling for new and untried adjustments, and separation and divorce may seem to many to be one form of adjustment of conflicting wants and values.

In contemplating divorce, what fears may be aroused in the woman? In the man?

Loneliness is probably the most omnipotent and painful fear for both man and woman. Frieda Fromm-Reichmann states that the de-

gree of a person's need to depend on others and the degree of anxiety aroused in him by the threat of isolation, depends upon personal development, but the fear of isolation and loneliness is present in everyone. Marriage is at once the most intimate of relationships and embraces more facets of an individual's personality than do other adult relationships. Loss of this relationship, by and large, therefore, represents a loss of a great number of human satisfactions. Failure in any human relationship, in our culture, carries with it some stigma of shame for the failure, some guilt and question about oneself and one's adequacy. For the woman, there may be loss of adequate support and the necessity once more to earn her own living; also help in the support of her children. Usually the woman is responsible for the day-to-day rearing of the children, and this imposes a dual burden. She is again faced with the possibility of competing in the marriage market. In addition to loneliness and the lack of home care, a man may face complicated problems in the financial field. It is more expensive to support two domiciles. Should he marry again, he may be faced with supporting two families, neither adequately. If he remains unmarried, his opportunity for building a sustained and satisfying emotional relationship is limited. His relationship to his children must, of necessity, be piecemeal and unsatisfying. In many instances a man feels unduly and unfairly treated by our divorce laws.

Does age have an effect on the adaptability of the partners to their new single life?

While the adaptability of.the individual is not necessarily related to age, but tied in more closely with his total personality structure, the possibilities for finding satisfactions within the social situation differ within the varying age-groups. Obviously, a man or a woman who divorces in the early twenties may find more available partners for a second marriage, than will a woman or man in their middle years, or later life. Establishing a new way of life, perhaps finding employment after years of being a housewife, and finding new friendships present greater problems for the older person.

Are most divorced individuals emotionally disturbed?

"Emotionally disturbed" is a very vague characterization with no clear scientific criteria. Everyone is emotionally disturbed in varying degrees during periods of stress. Studies indicate that divorce is the result of tension and conflict in a relationship between two people,

where each fails to meet the needs of the other to a satisfactory degree. This may be due to many different combinations of factors, e.g., differing cultural backgrounds, differing attitudes, values, and ideals.

If people are emotionally disturbed after a divorce, is it a result of the divorce, or could they have been emotionally disturbed before? Is the death rate, suicide rate, or illness rate higher among divorced persons than among the widowed or married?

The ability of an individual to handle his life situation constructively is related to the degree of flexibility, stability, and maturity he possesses. In many instances partners bring into marriage unresolved or unsatisfied needs from childhood, which impose too heavy a burden on the marriage relationship. For these persons, divorce represents another failure to secure wanted satisfactions and adds to the individuals' unhappiness.

We have not been able to ascertain any reliable statistical information as to whether the death rate, suicide rate, or illness rate is higher among divorced persons than among widowed or married persons.

When might divorce be considered a rational, nonneurotic course?

Leon Saul defines a neurosis as "essentially a persisting disturbed childhood emotional relationship to the parents (and perhaps siblings)," which influences other relationships. A nonneurotic course of action would thus be one that is determined by the reality factors involved in the specific situation. When two individuals have some understanding of their interpersonal difficulty, and their own part in it, with recognition that it is impossible or improbable that sufficient change will be made to create a satisfactory relationship, a decision to divorce may be essentially healthy and mature.

Is it possible that divorce might have a better effect on a child than would the continuance of the marriage?

Yes. It is not possible for parents in serious conflict to create a happy home without undue tensions, simply by willing to do so. Where couples have tried in all possible ways to effect a solution to their difficulties and have not been able to do so, it is probable that the child would be less traumatized by living with one parent in a home relatively without conflicts.

In a study by Paul H. Landis ("The Broken Home in Teenage Adjustments") on adolescent adjustment, the data suggested that children

from divorced parents may not have, on the average, a higher number of problems than children from separated homes.

Is it possible that the decision to reject divorce as a way of dealing with marital problems might be quite abnormal?

Yes. If either one or both marriage partners have made every effort to understand and change an unhappy or destructive relationship with no success and there is no cultural or religious conflict regarding divorce, a desire on the part of one or both to remain in the situation might indicate a neurotic need to suffer, or to inflict pain. In other instances, a determination of one partner to hold the other in the marriage despite unhappiness might have as an underlying motivation very deep and immature dependency needs, or a desire to punish the partner for rejection, or a need to possess (rather than love) the partner, or complete self-centeredness which does not recognize another's wants or needs.

How do parents who are planning a divorce explain to their children the new relationship?

It would be most helpful to the children if the parents could talk with them together, that is, as a unit, explaining that it seems best for them as man and wife to live separately, and that they will be getting a divorce; that this does not mean, however, that either parent will feel differently toward the children; that the father, if he is the one who will be living elsewhere, will plan to see the children regularly and will still be their father when they want or need him. Since children often feel that they are responsible for the separation of the parents, because of imagined or real behavioral difficulties, it is important to let the children know that the reason for the divorce is the feeling between the mother and father rather than anything the children have done.

If either parent has custody of the children, what problems are likely to arise in bringing them up?

Children need to feel loved and wanted, to have a feeling of belonging and security. Before divorce has taken place, the security of the child may be badly shaken. When one parent leaves, the child may feel deserted and this may, in turn, increase his feelings of rejection and insecurity. The child may long for the absent parent and feel that the parent with whom he is living is to blame for his loss. Each time the parent visits the child, the child may live through the separating

process anew. The parent who has custody may feel that he has the greater burden and may resent this. For the child the question of sexual identity may be hindered as children learn how to be men or women through identification with the parents of the same sex. Also, the capacity to relate to the opposite sex may be damaged through unresolved feelings of rejection or anger, and intermittent relationships. Many practical problems arise, such as care of the child while a parent works, discipline, social affairs requiring a particular parent and the child's feeling that he is different from others of his peer group.

Do substitute parents such as a friend or relative provide satisfactory adjustments for the children?

No. Friends or relatives may ease the problem, but as a rule they cannot replace the basic parent-child relationship.

How is it possible for the parent to make new relationships with the opposite sex without arousing unhappiness or confusion in the children?

Children depend for their security and maturation upon the steadiness of warmth, love, and understanding of the adults around them, rather than necessarily upon the sole possession of the parent's attention. If the child can be given this kind of understanding and environment by the parent, it is probable that any new relationship with the opposite sex may be handled without major emotional difficulties. Certainly the children will have a reaction and will need both explanation that the new partner is not replacing the father or mother per se, but is another person who may be an interested and loving friend to the child. At the same time the child needs assurance that the addition of a new person in the life of one parent will not necessarily change the parent's love or acceptance of the child.

If the wife or husband remarries and the original spouse still has visiting rights, how can this be properly handled for the best interests of the child?

An effort to help the child understand that the new spouse does not take the place of his own mother or father, but will be an added interested and caring person is an essential first step. If it is possible for the real parent to visit with the child, without the immediate presence of the new spouse, less tension and conflicts will be created for

the child. This might be arranged through visits at the home of relatives or in a nonemotional setting.

Do more men remarry than women? What may be the reasons for this?

According to Paul Glick in *American Families,* "Divorced and widowed men had higher remarriage rates than divorced and widowed women. . . . Remarriage rates were higher for white women than for nonwhite women during the late 1940's among widowed and divorced women in each age-group under fifty-five years old. An analysis of vital statistics data on the number of divorced in the early 1950's and census data on the previous marital status of persons who had remarried during the same period suggests that about one-half of the divorced women remarry within five years after divorce and that two-thirds will eventually remarry. About three-fourths of the men who obtain a divorce eventually remarry."

Some of the suggested reasons for the differential rate of remarriage between men and women are: (1) If a first marriage has been unhappy. the divorced woman may fear a repetition; or if happy, that it would be disloyal to the previous mate. (2) A woman receiving an income that will stop at remarriage may hesitate to remarry. (3) An older woman may fear that in marrying an older man she will have an invalid to care for. (4) A woman may not want to share her children with another man; or risk the possibility of an unhappy relationship between a new husband and her children. (5) A woman who has had an unsatisfying sexual relationship in marriage may prefer to remain unmarried.

Do many divorced persons marry "on the rebound"? How successful are these marriages?

It is impossible to answer this question accurately because no statistics are available on this subject. It is probable that some do marry because of loneliness or hurt, or desire to prove that they are capable of attracting and securing love from the other sex. Census figures indicate that during the period January 1950 to April 1953, 12.1 per cent of divorced persons remarried in less than one year after their divorce.

Does the divorced man or woman engage in more frequent sexual activity than he or she did in marriage?

This question cannot be answered statistically, because no facts are available. It has been conjectured that a high proportion of

divorced men and women have sexual relations with their future spouses before remarriage.

Why does it seem that a divorced woman at the age of thirty has a better chance for remarrying than a single woman at the same age has to marry for the first time?

There are many probable factors involved. A girl who has reached the age of thirty without marriage may well have some intrapersonal conflict that has fought against marriage, i.e., fear of the male sex, fear of a close relationship, unwillingness to leave the parental home and assume mature responsibilities, or a strong drive toward independence and personal achievement in a career. The divorced woman has, at least, been able to move toward a heterosexual relationship, and has had some experience in living in an intimate relationship. Culturally, the girl who has been "chosen" would represent a more desirable person to the American male.

What problems does a divorcée have in her new life as a single woman?

The specific problems would depend upon the individual's living situation and personality. Generally, the following problems would be existent: a changed economic situation, a change in social status, and probably the necessity for developing a different kind of social life, dealing with the problems presented by the children as a one-parent family, need for companionship and affection, including sexual expression; perhaps returning to work, or completing an education as a prelude to working, handling the community's attitude toward divorce, and the often predatory attitudes of both married and single men toward a divorced woman.

What might be the fears of a divorcée in contemplation of a second marriage? Of a divorced man?

One of the primary fears of each would be that of failure in another marriage; concern about the attitudes of the children toward the new partner; economic problems because the man may be obliged to divide his income between two family groups; feelings of the new partner toward the former spouse, with some lingering doubts about the new partner's involvement with his former spouse. Depending upon the situation, there might be concern about each spouse's own family or the community attitude toward remarriage, especially in certain religious groups.

Is there a relationship between divorce and the juvenile delinquent?

The relationship between divorce and behavioral problems is not at all clear, because no adequate studies have been made. The study most frequently quoted, *Unraveling Juvenile Delinquency*, by Sheldon and Eleanor Glueck, relates juvenile delinquency to several types of broken homes: (1) divorced, (2) widowed, (3) separated. It is not clear, however, what problems the delinquency may have raised in the divorced and separated homes, or how much conflict and disorganization existed in the marital relationship prior to the divorce. On the other hand, there is no question but that a child needs the father (who is usually the absent parent) as an object of love, security, or identification, and separation from him would tend to create problems in adjustment and conflict for the child.

Is the divorced man looked upon unfavorably by those who have influence on his business career?

The question concerning a divorced man would, in business, by and large, be related to his stability as a person and the reasons for his divorce, rather than disapproval of divorce per se. Occasionally divorce creates a job hazard.

Does society still tend to put a stigma on the divorced woman more than on the divorced man?

Divorce is strongly tied to several sets of value systems in our culture relating to the family. Moral proscriptions against divorce are generally weaker, but marital stability is morally approved of as a desirable social value, and culturally the woman is expected to provide the greater degree of stability in the family. Conversely, when a woman is divorced, she is usually subject to greater scrutiny and more severe judgment on conduct than is a man in a like situation.

Is a divorced man "a poor risk"?

The fact that a man is divorced does not in and of itself constitute a basis for considering him a "poor risk." The reasons for the divorce, the degree of responsibility he continues to exhibit in caring for his children, financially and emotionally, his general behavioral pattern and his reliability in work would all have some bearing on his reputation and thus on his capacity to form new relationships of a satisfying nature.

What part might friends and relatives of a divorced couple have in helping them adjust to a new life?

William J. Goode, in his study, *After Divorce,* points out that there are no ethical imperatives for relatives or friends that would make them feel constrained to furnish material or emotional support during the crises and afterward to the divorced man or woman. Relatives and friends can help with the period of adjustment and afterward through attitudes of understanding and support, through assistance in finding new friends, or jobs when necessary, and with the economic and emotional problems of the children in a new and divided home.

Of what use are social clubs specifically designed for the divorced man or woman?

Usually an individual's social life is subject to considerable change after divorce. Friends may find it necessary to choose one partner to the exclusion of the other, and either partner may find that his previous social life offers no opportunity for meeting prospective partners for remarriage. Social clubs specifically designed for the divorced man or woman offer an opportunity for meeting others with like problems, or a group with which both the divorced man or woman may identify, and a resource for potential future mates. Divorcée Anonymous, Inc., Single Parents, Inc., and Parents without Partners have served as very real sources of help to divorced persons in those communities in which these groups are organized.

Does the fact that more men and women are achieving higher education influence the divorce rate?

Inasmuch as there is less divorce among persons of college education than among persons of lesser education, the increase in the number of college-educated persons might tend to influence the divorce rate. The recent trend, however, has been for men and women to marry while in process of education and thus at a younger age and there is a close relationship between early marriage and instability of marriage.

Does the new emphasis on educating young people in the nature and hazards of marriage influence the divorce rate?

It is hoped that an understanding of the roles and responsibilities, attitudes and feelings of man and wife may have a beneficial effect on

the stability of present-day marriage. Education for marriage has been in existence, largely on the college level, for the past fifteen to twenty years, so that there has been insufficient time to form conclusions.

What effect does psychotherapy have in solving the emotional problems of one or both of the partners who are contemplating divorce?

Psychotherapy may be helpful to the individual partner, depending upon the kind and intensity of problems he or she has. Uncovering sources of unconscious hostility, guilt, and fear, and clarifying their influences on the marriage, may contribute to a more satisfying marital relationship. It is also possible for an individual to secure help with his own conflicting feelings without in any way stabilizing the marriage. The marriage relationship is a complementary and reciprocal one, in which both partners contribute either to the constructive and healthy relationship, or to the destructive one, and usually it is necessary for each partner to secure help with his part in the difficulty before beneficial change occurs in the marriage.

What success has marriage counseling had in keeping potentially good marriages together?

Marriage counseling has as its primary concern an understanding of the way in which each partner projects his attitudes, feelings, wants, needs, and daily behavior into the marital relationship. As each partner comes to understand and wants to change his part in the difficulties between them, a potentially good marriage can be stabilized and strengthened. We find that in approximately 65 per cent of the couples counseled, the marriage is strengthened and stabilized through a constructive resolution of the problems presented; in another 30 per cent little or no constructive change results; and in the remaining 5 per cent there was retrogression.

What success has the advice of friends, relatives, and ministers had in helping a marriage to stay together?

This is a question that cannot be answered factually. However, it has been our experience that "advice" usually does not contribute to the stability of a marriage to any great extent. Since the difficulties in marital unhappiness lie within the interpersonal relationship, help to be effective must encompass an understanding of the individual and the interpersonal dynamics within the marriage, and be geared to-

ward assisting each partner to gain an understanding of his or her part in the difficulty, and how to change it. Such marriage counseling is a professional task.

What agencies or institutions are there in the community specifically concerned with the problems of divorce?

There are many social agencies throughout the country offering help with marital problems and divorce. There are family service agencies in more than two hundred cities, offering skilled marriage counseling services. Some family courts now have a staff of trained counselors. The American Association of Marriage Counselors has a list of qualified members living in various communities throughout the country. The National Council on Family Relations, 1219 University Ave., Minneapolis 14, Minnesota, also carries on an extensive program of public education and research. Information concerning resources may be secured by writing to the American Association of Marriage Counselors, 27 Woodcliff Drive, Madison, New Jersey, or to the Family Service Association of America, 44 East 23rd Street, New York 10, New York.

DREAMS

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What is a dream?

A dream is a type of thinking that goes on when one is asleep. The dream type of thought process is characterized by vivid sensory images, mostly visual, but also auditory (speech), kinesthetic (sensations of motion), tactile (touch), and occasionally gustatory (taste), or olfactory (smell). The dream is a form of hallucination, and while experiencing it, the dreamer participates in it and accepts it as real. The conviction of reality is one of the most striking characteristics of dreams.

How often do dreams occur in one night's sleep?

Until recently the answer to this question was not known. Since 1954 there has been a breakthrough in knowledge of dreams and dreaming as a result of the experimental work of Nathaniel Kleitman and William C. Dement, and their co-workers in the Physiology Laboratory of the University of Chicago. These investigators discovered a number of objective physiological criteria that tell when dreaming is actually in process. By taking all-night continuous recordings of brain waves (electroencephalogram) and eye movements (electrooculogram), as well as of other physiological variables such as heart rate and respiration rate, they were able to demonstrate that dreaming is associated with a definite brain wave stage and that it is always accompanied by rapid vertical and horizontal eye movements. The eye movements have been found to be correlated to the dream content, that is, the eyes move, just as in waking, in relation to the movement of objects and events in the dream as the dreamer either watches them or participates in them.

Furthermore, dreaming occurs in a definite cyclic pattern, there being usually four periods of dreaming in seven or eight hours of sleep. The first period does not begin until about an hour or an hour and a half after the onset of sleep, and usually lasts about five to ten minutes. The succeeding periods are generally longer, sometimes lasting as long as an hour. The dream periods occur in what is called Stage I of the

E.E.G. (electroencephalogram), and between them sleep is character-
ized by other types of brain waves (Stages II, III, and IV). An interval
of about ninety to one hundred minutes separates the onset of one
dream period from the next. On an average, the third and fourth
dream periods tend to be longer than the earlier ones.

Does everyone dream?

This dream-sleep cycle has been found in every individual so far
studied, and the number now runs into the hundreds. We may say,
therefore, that every normal person dreams every night of his life.

How much does the average normal person dream?

The dream-sleep cycle is relatively stable and the amount of
dreaming rather surprisingly constant. The average person in his
twenties will spend about 20 to 22 per cent of the night in dreaming.
This is far greater than anyone had heretofore supposed.

Are there age differences in the amount of dreaming?

Preliminary data suggest that the amount of dreaming may be at
its maximum during the first two years of life, when as much as 40
per cent of the night may be spent in dreaming. It is likely that visual
dreaming may start at about three or four months of age. This neuro-
physiological cycle is present from birth. Dreaming in sensory modal-
ities other than visual may begin at birth or shortly thereafter, and
especially in relation to the revival in the dream of mouth sensations
(taste, smell, touch, pressure) involved in the nursing experience.

Other age differences have not yet been thoroughly worked out, but
the evidence suggests that after age fifty there is a considerable decline
in the amount of dreaming—as low as 12 to 15 per cent of the total
night's sleep. Differences between the sexes in the amount of dreaming
is negligible.

How long does a dream usually last?

The objective E.E.G. rapid eye movement of investigating dreams
reveals that they last from about a minute or so to longer than an hour.
Dreams are extended in time and do not occur instantaneously as many
have thought. Although there may be serious time distortions in
dreams, many people can roughly estimate how long they have been

dreaming. Longer dream narratives have been shown to be related to longer periods of dreaming and the length of the dream narrative is roughly proportional to the length of the dream, as measured on the E.E.G. recording. The scanning eye movements that occur with the hallucinatory dream obviously take time to be executed.

Do dreams occur in black and white or color, or both?

Dreams generally occur in black and white; they are bleached of color like a movie. However, there are some people who always, or most of the time, appear to dream in vivid color. Many people who usually dream in black and white occasionally dream in color. In spite of the fact that most people dream in black and white, if they are questioned closely it will be found that in perhaps three-quarters of all dreams there may be one or two color elements. In this sense dreaming in color is more frequent than has been thought. The exact function of color in dreams is not known. The sensory elements in dreams—visual, auditory, kinesthetic—seem generally to be toned down. The bleaching in dreams appears to be related to the need to inhibit the emotional intensity of the dream. When certain impulses break through in dreams, color may appear.

Is dreaming necessary?

Dreaming appears to be an important and vital psychobiological function. It is very likely that the suppression of dreaming results in serious mental disturbance. In recent experiments with human subjects, by Dement and this writer, dreaming was suppressed by awakening the subjects every time they began to dream, as indicated by the presence of eye movements and Stage I of the E.E.G., and keeping them awake for several minutes. Under these circumstances a compulsive urge to dream develops. The subjects make increasing numbers of attempts to dream as the compulsive urgency builds up night after night. If such an experiment is carried out for five successive nights, the attempts to dream may increase from seven the first night to thirty on the seventh night. When the subject is then allowed to sleep without interruption for a number of nights, it is found that his dream time is markedly elevated. A dream deficit builds up during the nights of dream deprivation and this deficit is compensated for by increased dreaming during the subsequent recovery nights.

Dream-deprived subjects develop mild mental disturbances such as

difficulty in concentration, some tension and anxiety, trouble with motor coordination, etc., but no serious breakdowns. It is believed, however, that more prolonged and intensive dream suppression might lead to psychosis, although this has not yet been demonstrated. It has long been known that prolonged sleep deprivation, for periods of three or four days, does result in serious psychotic breakdowns with the development of delusions and hallucinations. It is believed that this is because prolonged sleep deprivation also results in serious dream deprivation until a large dream deficit is built up, which finally results in the dream cycle breaking through into the waking ego. When this occurs, the subject is dreaming in the waking state, that is, he hallucinates and becomes delusional. Psychosis is like a waking dream.

Dream suppression has also been brought about by administering a combination of Nembutal, one of the barbiturate sedative drugs, and Dexedrine. When sleep is limited to four hours a night for a week, the amount of dreaming is decreased, a dream deficit accumulates, followed by increased dreaming during the subsequent recovery period. It is not known whether people who claim to sleep only four hours a night adjust their dream cycle so as to get in the normal amount of dreaming.

Do people in primitive cultures dream as much as those in more advanced cultures?

In terms of the recent findings on the dream cycle, it is improbable that people in primitive cultures show any marked variations from the figures mentioned. In considering the problem of the amount of dreaming, it is important to distinguish the objective fact of dreaming, according to the criteria already listed, from the remembering or recall of dreams. There is little relation between the amount of dreaming and the degree of recall the next day. The recall of dreams depends upon other psychological factors, such as the need to communicate dreams. In primitive cultures where a high value is placed on dreams for magic or other reasons, dream recall may be very high. Or in special circumstances, such as in psychoanalysis, the use made of dreams and the need to communicate them to the analyst may produce a high degree of recall or, sometimes, the opposite.

Do artists and creative people dream more than others?

There is no evidence that this is the case.

Do mentally ill people dream more than others?

This question is just beginning to be investigated. There is some evidence that the dream-sleep cycle is disturbed in certain forms of mental illness. In one recently studied patient who developed an acute paranoid psychosis, total dreamtime at the height of the psychosis was 59 per cent. It is very likely that further investigation will reveal variations in the amount of dreaming and other disturbances in the dream cycle of the mentally ill.

Do people who never remember dreams actually dream?

Yes. Recent studies have shown that so-called nonrecallers, that is, individuals who rarely or never remember dreams, possess the same dream-sleep cycle as others. Their failure to recall is not due to the absence of dreaming, but rather to psychological factors, such as repression, that cause forgetting.

What is the difference between dreams, fantasies, hallucinations?

Dreams are generally nocturnal and take place in sleep. Fantasies occur in the waking state, and also in mental states intermediate between sleep and waking. A daydream is a type of fantasy. It resembles dreams in some ways but is also closer to waking thought. So-called hypnagogic fantasies occur while one is falling asleep and hypnopompic fantasies during the process of waking. They may closely resemble dreams but are not accompanied by eye movements. The night dream is a type of hallucination. The term, hallucination, however, is mostly reserved for pathological mental experiences in which inner perceptions are projected outward and believed by the person to be real perceptions. Such experiences occur in various types of psychosis, such as schizophrenia. They may also occur when one is under the influence of such drugs as mescaline or lysergic acid diethylamide (L.S.D.). In severe alcoholic intoxications, such as delirium tremens, hallucinations are prominent, e.g., the well-known hallucination of pink elephants. These pathological hallucinations occur in the waking state and may involve all sensory modalities: vision, hearing, touch, smell, taste, etc.

Why do dreams occur?

This question still presents some unsolved mysteries. Sigmund Freud believed that dreams have two main functions: (1) they serve as a

safety valve permitting the partial discharge of repressed, instinctual drive energies, especially indestructible unconscious wishes from the infantile past; (2) they serve to preserve sleep by binding disturbing stimuli, that is, excitations arising as the instinctual drives press toward discharge, and stimuli that impinge on the psychic apparatus either from the interior of the body or from the outside. The so-called dreamwork, with its various mechanisms such as displacement and condensation, disguises and distorts the meaning of the dream, and inhibits and suppresses disturbing emotion, so that the dreamer is allowed to continue his dream without awakening. When the dreamwork fails in its function, anxiety may become so intense that the dreamer awakens.

Sigmund Freud's ideas about the function of dreams are still valid, but may have to be extended to include the recent findings on the dream-sleep cycle. The cycle provides a neurophysiological correlate to dreaming. It is present at birth and antedates visual dreaming.

The dream-sleep cycle is present in monkeys, dogs, and cats, and these mammalian forms have rapid eye movements during stages of the E.E.G. corresponding to Stage I in man. There is good reason to believe that these animals dream, though their dreams must be on a much simpler level than man's.

The total amount of dreaming on any particular night, that is, daily variations, may in part be determined by what has gone on in the person's life the day before. If the person has been disturbed and if unconscious wishes and conflicts are stirred up, there may be more dreaming the following night. In very disturbed individuals, borderline or potentially psychotic, who are in chronic states of emotional tension, total dreamtime may be persistently higher than normal, the dreams serving as a safety valve and draining off accumulated instinctual drive pressures.

Dreams are not caused or precipitated by external stimulation such as noises, but such stimuli, when they impinge on the sensory apparatus during sleep, will be incorporated into an ongoing dream and partially determine its content. Such stimuli, when administered experimentally during nondreaming stages of sleep, do not arouse a hallucinatory dream with the associated rapid eye movement. Internal stimuli arising from hunger, thirst, a full bladder, etc., also do not appear to cause dreaming, but may determine the content of dreams. There is no evidence that eating before sleep causes dreams.

Are dreams brought about by recent events, or by past occurrences?

The relationship between recent and past events in dreams was one of Freud's most significant contributions. It cannot be said that either recent or past events cause dreams, since dreaming seems to be built into the organism, anchored in the dream-sleep cycle, but both types of events are involved in every dream. Freud showed that every dream incorporates one or more recent, usually indifferent impressions, and he called these *day residues*. These preconscious day residues either arouse past memories associated with an unconscious wish and combine to form the manifest dream, or the latter reach out and fuse with the day residue. Experimenters, as well as this writer, have demonstrated that subliminal perceptions (perceptions from which attention is deflected during the day) are extensively utilized as day residues and go to make up the manifest pictures of the dream. The organism is constantly bombarded during the day by thousands of subliminal sensory impressions which, though they do not reach consciousness, nevertheless form memory traces. These preconscious memory traces are subjected to all the so-called primary process (the type of mental activity and thought process that is characteristic of unconscious mental life) mechanisms of the dreamwork, are raised to hallucinatory intensity, and form much of the manifest structure of the dream.

Are all dreams wish fulfillments?

According to the psychoanalytic point of view, which represents the predominant view at the present time, all dreams can be analyzed and shown to be wish fulfillments. The wish is a designation for a repressed unconscious, instinctual drive representation that is striving for discharge into consciousness. Memory images of past events, associated with the unconscious wish, combine with the memory traces of the day residues; the entire mass of latent material is subject to the dreamwork and the mechanisms of the primary process, the final outcome being the distorted, disguised, and fantastic structure that we experience as the hallucinatory dream.

Do dreams fall into various categories? What are they?

Dreams can be categorized as: (1) Punishment dreams, in which the intervention of the superego, formerly called the censorship, is more in evidence. (See *Ego*) In these dreams, the unconscious need for punishment takes precedence over the ordinary wish-fulfilling function.

(2) Anxiety dreams, in which the function of the dreamwork fails and the unconscious, forbidden wish is permitted to arouse excessive amounts of anxiety, thus awakening the subject. In war neuroses or other types of traumatic neurosis, anxiety dreams that are repeated re-enactments of the traumatic incident are very common. These dreams are attempts to master the traumatic memory by constant repetition of it. (3) *Pavor nocturnus*—these are anxiety dreams in the form of nightmares, very commonly found in young children. (4) Typical dreams: Freud designated a number of dreams as typical because almost everyone has dreamed them and they seem to have the same meaning for everyone. He included in this category embarrassing dreams of being naked, dreams of the death of persons of whom the dreamer is fond, dreams of flying and of falling, examination dreams, dreams of missing a train, dental dreams of tooth extraction, and finally, water and fire dreams.

Do most people experience nightmares and dreams of violence? What might cause these dreams?

Almost everyone at some time in his life experiences nightmares and dreams of violence. Nightmares are a frequent and normal occurrence in early childhood. They come about as a result of the child's struggle with his sexual and aggressive instinctual drives and the large charges of anxiety these can bring about. Forbidden wishes escape censorship during sleep and emerge in the dream but result in severe anxiety. In general, nightmares, which are anxiety dreams, come about because of the breakthrough of unacceptable unconscious wishes that have acquired great strength and elude the censoring effect of the superego.

Does dreaming disturb the restfulness of sleep? Is sleep more restful for those who do not recall dreams than for others?

Dreaming does not disturb the restfulness of sleep and, in fact, the uninterrupted flow of the dream-sleep cycle, with its average component of about 20 per cent dreaming, is a normal phenomenon. If anxiety dreams intervene during the night, the person may awaken and in this way sleep will be disturbed. Sometimes people will sleep very poorly in order to avoid dreaming because of fear of their dreams. It is not that dreaming disturbs the restfulness of sleep, but that poor sleep, with frequent awakenings, may disturb the dream cycle or re-

duce the normal amount of dreaming. This may sometimes happen when a person is very tense, anxious, or emotionally upset and sleeps restlessly with frequent awakenings.

What causes nocturnal emissions or "wet dreams"? Who has these "dreams"?

Almost all adolescent boys have nocturnal emissions as part of their normal development. Such dreams are brought about by accumulated sexual tensions that find their outlet during sleep. If the adolescent is masturbating frequently or has other sexual outlets, wet dreams may be infrequent; if other sexual outlets are minimal they may be frequent. Older males also may have nocturnal emissions if they do not have other sexual outlets. The nocturnal emission is a remarkable phenomenon that attests to the importance of the hallucinatory dream. It indicates the degree of reality with which dreams are experienced. That is, without direct stimulation or friction of the genitals, and only through the participation in the imaginary events of a sexual situation depicted in the dream, a boy has an ejaculation and experiences all the sensations of an actual sexual event. Only in the most unusual and pathological mental states can this be duplicated in the waking state. (See *Adolescence*)

Is it possible to dream solutions to problems that were unsolvable while awake? Why is this so?

It is improbable that the solutions of intellectual problems occur in dreams. Freud believed that everything appearing in dreams as the ostensible activity of the function of judgment is to be regarded not as an intellectual achievement of the dreamwork, but as belonging to the material of the dream thoughts and as having been lifted from them into the manifest content of the dream as a ready-made structure. Dreams involve a more primitive, primary process type of thinking and not the high level, secondary process thinking that is involved in the solution of intellectual problems. Dreams are wish fulfillments and are concerned with the discharge of aggressive and libidinal instinctual drives, not with problem solving in the ordinary sense. There is evidence, however, that thought activity goes on during the nondreaming stages of sleep and that these thought processes are more like waking, preconscious thought processes, closer to ordinary cognitive thinking. It is known that many creative people go to sleep with a problem that

is troubling them and awaken with the answer, which may have been elaborated during these nondreaming periods.

Is it true that if one dreams of his own death or accident, he will awaken before it happens?

Generally this is the case. The reason is that as the catastrophic event in the dream is about to happen, so much anxiety is generated that the dreamer awakens. However, people do sometimes dream of being injured and do not awaken at the time of the dream.

Can the future be predicted through dreams? Why might this be so?

The answer to this question can best be given in the words of Freud, ". . . and the value of dreams for giving knowledge of the future? There is of course no question of that. It would be truer to say instead that they give us knowledge of the past. For dreams are derived from the past in every sense. Nevertheless the ancient belief that dreams foretell the future is not wholly devoid of truth. By picturing our wishes as fulfilled, dreams are after all leading us into the future. But this future, which the dreamer pictures as the present, has been molded by his indestructible wish into a perfect likeness of the past."

Can dreams influence one's attitude on awakening?

Dreams, especially uncanny or bizarre ones, can influence the general mood of the following day. This may be partly a reaction to the dream content itself; for example, one can feel guilt or horror at some heinous deed committed in a dream. The mood of such vivid dreams may color the mood of the day. Also, the very impulses and emotions that produced the dream may determine the attitude and feeling of the subsequent day.

Is it possible to satisfy a physical desire by dreaming about it?

Since dreams are wish fulfillments and serve to discharge instinctual drive energies, they do satisfy desire. The ultimate degree of this gratification varies with the kind of desire involved. For example, sexual wishes of certain kinds may be gratified, not only on a psychic level, but on a physiological level as well. The wet dream or nocturnal emission has already been discussed. Females, not infrequently, also experience orgasm in dreams and this is probably associated with the physiological sexual response. No real gratification of hunger or thirst

can be attained in dreams, but the hallucinated psychic experience probably reduces the need temporarily and postpones the necessity for immediate gratification. An example of this type of dreaming is the hungry infant who, in the absence of the mother, raises the memory traces of past experiences of the mother, the breast, and nursing to hallucinatory intensity.

Can dreams be induced? Can one dream a favorite dream by concentrating on it before falling asleep? Is there a difference between an induced dream and one that occurs naturally? Can narcotics, drugs, alcohol, or hypnosis induce dreams?

The real problem is whether the dream process and the dream-sleep cycle can be influenced; the answer is, "Yes." In psychological terms, the dream is due to an interaction of the id, ego, and superego. Dreaming can be influenced by the ego. It is possible to determine the dream content, in part, by concentrating on the dream. At least, certain people can instruct themselves to dream about a certain content. Although they may influence the manifest content of the dream, the latent content is determined by unconscious forces beyond the individual's control.

Dreams can be induced in hypnosis in two ways. While the person is in the trance state he can be given a suggestion to dream and he will produce what appears to be a hallucinatory dream, even accompanied by the same kind of eye movements that occur at night. Or the person can be given a posthypnotic suggestion to dream that night. These induced dreams may have all the characteristics of spontaneous dreams, though some of them may be less dreamlike and have more of the qualities of waking thought.

Certain drugs can affect the dream-sleep cycle. The barbiturates and Dexedrine appear to suppress dreaming. Alcohol, too, may be a dream suppressor. Drugs, such as mescaline and lysergic acid diethylamide, can induce hallucinations in the daytime. It is possible that they increase night dreaming.

Do some individuals try to sleep more, and to dream more, as a means of retreating from reality into a dreamworld?

Certain mentally ill individuals, sometimes early in a schizophrenic process, may sleep a great deal. This may partly be an attempt to escape from painful reality. Such individuals may also have an increased pressure to dream and the excessive sleeping may give them a

chance to dream more. In a sense, this may be called retreating from reality into a dreamworld.

Are there successful methods for helping a person to recall dreams?

Many individuals who undergo analysis or other forms of psychotherapy where stress is laid on dreaming may begin to remember dreams when they had not done so before. The increased attention to dreams and the motivations provided by the therapy may increase dream recall, but not the amount of dreaming. Anyone who, for any reason, becomes interested in his dreams, may begin to recall them better in the morning.

Can unpleasant dreaming be eliminated? How?

Unpleasant dreaming is not under the individual's control, and there is no way of eliminating it by conscious effort. Severe anxiety dreams or nightmares are determined by unconscious sources. Successful psychotherapy that gets at the roots of the conflicts producing unpleasant dreams, may eliminate such dreams.

What is the history of dream interpretation?

Ancient and primitive cultures used dream interpretation for the purpose of ascertaining the future. Dreams were looked upon as omens. A good example is the kind of dream interpretation related in the Bible about Joseph and the seven fat and seven lean kine that foretold the seven lean and seven plentiful years. The scientific interpretation of dreams begins and nearly ends with the name of Sigmund Freud, who was the first to really take the dream seriously and to demonstrate that it had meaning. Freud's book, *The Interpretation of Dreams,* appeared in 1900, and since then many analysts have contributed to dream theory, but the essential discoveries of Freud still represent the core of our knowledge.

Of what use are dreams in psychotherapy? Do dreams have meaning?

Freud called dreams the royal road to the unconscious. (See *The Unconscious*) The interpretation of dreams plays an important role in psychoanalysis and in many other forms of psychotherapy. (See *Psychoanalysis*) Because of changes in the balance of psychic forces brought about by sleep, repressed unconscious contents, related to a patient's conflicts and symptoms, emerge in dreams in a disguised and distorted

form. By the proper analysis of dreams, which requires that the patient produce free associations to the dream, and by differentiating between the manifest and latent content of the dream, it is possible to gather much significant material relating to a patient's illness, character make-up, etc. Freud's great contribution showed that dreams have meaning; that dreaming is a primitive form of thinking, which expresses the unconscious instinctual wishes and strivings of the individual. This primitive form of thinking does not utilize ordinary space-time categories and logical modes of expression or causality and is different from our usual form of conscious thinking. It uses strange condensations, displacements, and symbols. One can, however, learn to interpret this language.

What is the meaning of the term "symbol" as applied to dreams?

The psychoanalytic use of the term "symbol" is different from its usual meaning. A flag, for example, is the symbol of one's country, but in this instance the symbol and the thing symbolized are both conscious. In symbols, as applied to dreams, the symbol is conscious, but the thing symbolized is unconscious. Thus, a snake appearing in the dream is conscious but its meaning as a penis is unconscious. Although there are many symbols in dreams, they actually refer to a very few unconscious objects or functions. They can refer to the male and female sexual organs, to birth, death, family members, and primary body functions.

Are there symbols that are common to many individuals? What are they?

Yes. So much so that there is a tendency for symbols to be universal; however, they are in part culturally determined. It has been noted above that symbols refer to primary biological matters and the family, which are universal in all cultures. Thus, the male organ is universally symbolized by elongated objects and the female by receptacles or containers of one kind or another, such as boxes, etc. Many of these may be culturally determined, e.g., a church steeple, an airplane, an automobile, etc. All three of these are phallic symbols (symbols of the penis)—the church steeple by virtue of its shape and form, the airplane because it flies upward (erects), and the automobile because it is a powerful, intrusive, forward-thrusting apparatus. In the United States the automobile is perhaps the most common symbol to

appear in dreams because of its widespread and pervasive presence.

Water symbolism, the symbolism of flying, of falling, etc., are practically universal. Water symbolism, for example, refers to birth.

What causes recurrent dreams?

Recurrent nightmares, following traumatic experiences, are attempts to master the traumatic event. Other recurrent dreams are related to important, unresolved, unconscious conflicts. Periodically these are stirred up by events and an identical or very similar dream will recur.

Does a person have greater intelligence, insight, and humanity in dreams than when awake? Why? Is the opposite ever true?

The opposite is almost always true. Dreams do not have a great deal to do with intelligence, although complex verbal material or literary allusions will occur in the dreams of the educated. Dreaming, in a sense, represents the poetry-making activity of the psychic apparatus. Even very dull people may have beautifully constructed dreams Dreams do not have to do with intellectual activity but with the expression of instinctual drives, which are the same for all men. The meaning of dreams is distorted and disguised by the dreamwork. Hardly anyone has insight into his dreams or himself as a result of them, unless he later has occasion to analyze them by the psychoanalytic method. Most dreams remain obscure to the dreamer, and most people treat their dreams, as do children and savages, as foreign bodies that have little to do with them, as though they came from the outside and not out of the depths of their own minds. Whether one has greater humanity in his dreams than when awake depends upon one's definition of the term. If one means more humane, more kind, etc., the answer is, "No." Dreams discharge primitive sexual and aggressive drives, frequently very cruel—not humane—and very often forbidden or tabooed by the culture. Dreams do, however, deal with what is common to all human beings, the great instinctual strivings, especially indestructible infantile ones, shared by everyone.

Is one's true nature revealed in dreams? How?

As previously noted, certain aspects of one's true nature are revealed in dreams more than in waking life. The dreamer's unconscious conflicts, the particular vicissitudes of his instinctual strivings, come

to light in his dreams. On the other hand, part of one's true nature is also comprised by the forces of the personality opposed to the discharge of irrational or antisocial instinctual urges; therefore from dreams alone one cannot assess the full nature of a person's character or personality makeup. The dreams of some adolescents give the impression that they are psychotic, but this turns out to be untrue. It is only that adolescents may be passing through a phase of instinctual turbulence that finds expression in their dreams.

Can individuals other than professionals interpret dreams satisfactorily? Is it ever unwise to attempt this?

Only persons with special psychiatric and psychoanalytic training are really competent to analyze dreams. Individuals who have been analyzed or anyone with special training in the method may have some competence. It takes many years of training and experience to know when and what to interpret in a dream, even with patients in analysis. There may be times when it is unwise for laymen to attempt to analyze the dreams of others, but the harm that can come from such attempts can easily be exaggerated. Most people have such resistances to becoming aware of the unconscious meaning of their dreams that interpretations given them by inexperienced persons and at inappropriate times simply fall on deaf ears.

Based on current research and studies, what might be predicted about the importance of dreams in psychotherapy in the future?

As long as psychological methods of healing the mentally and emotionally ill are used, it is probable that dream interpretation will continue to play an important role. There is no more potent method than the analysis of the individual dream for throwing light on the unconscious, deeper layers of the mind. Current research, however, suggests the possibility that the control and manipulation, not of the individual dream, but of the total dream function as revealed in the dream-sleep cycle, may in the future, play a role in the treatment of mental illness. Such control may be brought about by drugs or other methods and may have effects on the course of the illness. It is too early to be certain of this, but there are hints of future possibilities.

DURHAM DECISION

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What is the Durham decision?

In 1954 the United States Court of Appeals for the District of Columbia Circuit, in an opinion by Judge David L. Bazelon, decided the case of *Durham v. United States.* This broadened the test for determining whether a defendant in a criminal case should be acquitted because of insanity: "an accused is not criminally responsible if his unlawful act was the product of mental disease or defect." The court noted that this rule "is not unlike that followed by the New Hampshire court since 1870."

The Durham court found the existing tests of insanity to be no longer acceptable: the M'Naghten right-wrong test was "inadequate in that (a) it does not take sufficient account of psychic realities and scientific knowledge, and (b) it is based upon one symptom and so cannot validly be applied in all circumstances"; the "irresistible impulse" test was also inadequate because "it gives no recognition to mental illness characterized by brooding and reflection." The new test was designed to allow the "expert" witness freely and fully to testify concerning any mental disorder suffered by the defendant. With such information, the jury would be in a position to make a better moral decision as to whether the accused should be held responsible.

What has been the acceptance of the Durham decision?

The substance of the Durham Rule has been enacted by the legislatures of the Virgin Islands and Maine; but, as of the end of 1961, the rule had been rejected by all courts that had considered it. However, the same arguments which persuaded the District of Columbia Court to formulate the Durham Rule have operated to liberalize the views of some other courts and legislatures on the issue of criminal responsibility. The importance of Durham is not reflected in its formulation of words but rather in its concept, under which the jury, in

weighing the issue of responsibility, is enabled to consider any and all testimony which bears upon the behavior of the accused.

The Durham Rule has been widely approved by the psychiatric profession and by many legal scholars. One of the chief criticisms has been that the term "product," as used in Durham, is an ambiguous concept; depending upon its interpretation, it is argued, this could result in either too many acquittals or could produce little change in the law. Later opinions by the District of Columbia Court have emphasized that "product" implies a "determinative" connection between the disease and the criminal act: "but for" the disease, the act would not have occurred.

What has been the effect of the Durham decision?

There has undoubtedly been some improvement in the depth and understanding of psychiatric testimony in trials in the District of Columbia. But the extent of the improvement continues to vary considerably with the temperament and abilities of the lawyers and expert witnesses in each case.

In the eight years since Durham, over three hundred people have been acquitted by reason of insanity. This is a marked increase in the number of such acquittals over the previous decade. But it still covers only a very small percentage of all criminal cases. The District of Columbia law provides that a person so acquitted must be confined in Saint Elizabeths Hospital until he has recovered and is no longer dangerous. About one third of these patients have been released, either unconditionally or subject to supervision from the hospital. The prolonged custody of some patients in mental hospitals has provoked active discussion of the protection of individuals from incarceration when therapeutic help is not in fact given.

EGO

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What is ego?

Ego is the Latin word for "I." It took on a special meaning when philosophers began to wonder about the difference between what was "I" and what was "not-I," or what was "self" and what was "not-self." Almost everyone who has thought about this problem has developed a different idea. These ideas about the ego, however, fall roughly into four classes. For convenience these may be called: the philosophical, the psychological, the psychoanalytic, and the structural.

What is the self—the philosophical ego?

Nearly everyone at one time or another has asked himself such philosophical questions as: "Who am I?" "How did I get here?" "Where was I before I was born?" "What would happen if I were someone else?" The "I" in these questions is the self. This is the first step in defining the ego: to distinguish self from everyone else in the world, and from everything else in the universe that is not-self. Here the ego is the self, and the self is what does the observing, thinking, and feeling necessary to find out what is not-self. Philosophers such as Immanuel Kant and René Descartes gave a great deal of attention to defining the ego from this point of view.

What is the real self—the psychological ego?

Psychologists such as William James were especially interested in the fact that what a person calls his self, and distinguishes from what is not-self, really includes two different aspects, which James called the I and the Me. If I can watch myself, there is one part that is watching and another part that is watched. The part that watches or knows is called the pure ego, and the part that is watched or is known is called the empirical ego. The pure ego—I—is something very special, about which it is hard to say anything; the empirical ego—Me—can be broken down into separate parts. I feel that my body, my clothes, and my profession, along with many other things, are part of Me. But if those

things change, the same I can think about the new things. Therefore, the pure ego—I—is my real self.

What is the ego that is commonly talked about today—the psychoanalytic ego?

Certain thoughts and impulses that enter consciousness do not seem to belong there, even though they come from the same mind as do the more comfortable thoughts and impulses. They are felt neither as I, like pure ego, nor as Me, like my body, but as "those things"— things that are foreign to both I and Me.

"Why do I think of those things?" means: "They come from something inside me that is not-I." Then what is that "something"? Sigmund Freud named it the "id." (Id is simply the Latin word for "it.") A more precise definition is that the id is that part of the personality structure that harbors the unconscious instinctive desires and strivings of the individual. The id has to be taken very much into account in considering what a person is really like; it is very much a part of his real self.

What Freud did, therefore, was to divide the real self into two parts: the ego and the id. He began to use the word, ego, to mean the part of the personality that was supposed to be in control, the prudent self, as opposed to the impulsive or unreasonable self, which he called the id. In this meaning, the ego is a special organ of the mind, just as the upper brain is a special organ of the body. This is the meaning of ego that is most commonly encountered in current reading: the psychoanalytic ego. (See *The Unconscious*)

How many real selves are there, or what is the structure of the ego?

Freud was mainly interested in how the ego worked. One of his pupils, Paul Federn, revived an old question in a new way to ask not only how the ego works, but also how the ego feels. This led anew to the study of states of mind, states of the ego, or ego-states. From studies carried on by the writer it appears that there are three types of ego-states that can be distinguished by self-observation:

1) Archaic ego-states, colloquially known as child ego-states, in which the individual feels and reacts as he did during a particular period of his childhood. The behavior that results from an active child ego-state is popularly called "childish" or "immature." More objectively, it can be called "childlike," meaning that it resembles the behavior of a child at a specific age level.

2) Adult ego-states, in which the individual makes a careful appraisal of his environment and acts accordingly, regardless of how he might have reacted as a child.

3) Parental ego-states, in which the individual, usually without realizing it, feels and reacts the way one or the other of his parents would have done in a similar situation, rather than on the basis of an objective appraisal.

From this point of view, the ego may be regarded as a collection of ego-states, and whichever one is active at a given moment is experienced as real self at that time. This is the structural view of the ego, and means that each person has at least three real selves. If he does something in a child ego-state, and later an adult ego-state takes over, he may then say, "I was not myself when I did that"; but at the moment he did it (with some exceptions in certain types of psychiatric disorders), he felt it was really he who was doing it.

According to Freud, what is the function of the ego?

In his *An Outline of Psychoanalysis,* Freud states that the ego is in control of voluntary movement and has the task of self-preservation. To perform this task, the ego acts as an intermediary between the id and the external world. The ego becomes aware of the environment, stores up memories, avoids excessive stimuli through flight, adapts to other situations, and learns to modify the external world to its own advantage.

In dealing with the id, the ego gains control over the demands of the instincts, deciding whether they should be allowed immediate satisfaction, whether they should be postponed for more favorable results, or whether they should be suppressed completely. And the ego signals dangers that are threatening either from outside or from the id, by experiencing anxiety.

In a way, the most important thing the ego does is to enable the individual to postpone action until the most favorable time, sometimes for years or even decades. Thus the ego may be called the organ of waiting.

How does the ego make its judgments?

The process by which the ego makes its judgments is called reality testing. It tests the possibilities of the current situation by careful appraisal and comparison with past similar experiences. Often the ego

works very much like a giant computer. In crossing a busy intersection, for example, the ego is making continuous estimates of the speeds of cars approaching from various directions, and from these estimates it makes decisions about what to do next. It can be seen from this example that not everything the ego does is conscious. In fact, a large and important part of ego functioning is unconscious.

What happens to the ego during sleep?

During sleep, the ego gives up its connections with the external world and undergoes far-reaching changes, according to Freud. These changes consist of a redistribution of mental energy. This redistribution is one of the reasons for dreams. A similar withdrawal occurs in certain severe psychiatric disorders (psychoses), under anesthesia, and under hypnosis.

Where is the ego located?

It is probable that the functions of the ego described by Freud are mainly located in the two large masses of the brain called the cerebral hemispheres, which occupy most of the skull.

The ego, in the philosophical sense of self, is felt to be at the base of the forehead, between the eyes, as pointed out by the Swiss psychologist, Edouard Claparède. Paul Schilder made the interesting observation that while going down in a fast elevator, the body may fall faster than the feeling of self, which is left slightly behind and seems to be above the head. When the elevator stops, it sinks back into the skull in the location mentioned.

What is the superego?

In Freud's system, the superego is the parental influence, left over from childhood, which forms a special agency within the ego—similar to that which we call "conscience." Since it is often opposed to the judgments of the ego, however, it is another force that the ego must take into account along with the id and the demands of the external world.

What is ego strength?

This refers to the ability of the individual to maintain his ego and its function of reality testing without undue interference from the id or the superego.

Can the ego be strengthened?

Yes. The indications are that the ego is similar to a muscle, in that proper exercise can strengthen it. Healthy people enjoy such exercises (for example, going to night school to study mathematics or ancient Greek) just as they enjoy physical sports. Less healthy people need professional advice when strengthening their egos, just as they need it when strengthening their bodies. An emotionally disturbed person should not undertake mental exertion without psychiatric help any more than a diabetic should go mountain climbing without medical advice. On the other hand, mental exercise is just as invigorating for a healthy person as physical exercise, and personal pride should stimulate people to avoid the onset of potbellied egos.

What is the effect of mental illness on the ego?

Mental illness, especially the more severe types called psychoses, always affects the ego, and it is the disturbance of the ego that usually calls attention to the fact that something is wrong. This applies to whichever description of the ego is used. In the philosophical sense, an individual suffering from psychosis is disturbed in his feeling of self. This is especially likely to occur in adolescence. In the psychological sense, there is confusion between the I and the Me. In Freud's sense, the id or the superego breaks loose from ego control, so that the ego no longer works effectively. In mild psychoses, the impairment may be well concealed; in more severe conditions, the workings of the overactive id or superego may be plainly visible, and relics of good ego functioning may be hard to find.

In the structural sense, the adult ego-state may be dominated, or almost entirely put out of commission, by a highly active child or parent ego-state that is struggling to take control. In severe cases, the ego-state that takes control may be that of a very young and very confused child. In depressions it is the superego, or parent, that has the upper hand. In manias, it is an overactive id or child. In schizophrenia, it is again the id, or a confused child. The confusion is most evident in the condition known as hebephrenic schizophrenia.

What can be done about restoring the ego to its normal functioning?

If the ego can be restored to normal functioning, the individual will be well again. In Freudian terms, this can be done by quieting down the id or superego so that the balance is restored and the ego

takes control; in structural terms, the child or parent ego-state is soothed so that the adult ego-state can maintain control once more.

The methods for accomplishing this include all the therapies available to the psychiatrist: psychotherapy, psychoanalysis, drugs, and shock treatment of various kinds. Most psychiatrists feel that hypnosis is not recommended in the treatment of psychoses, save for exceptional cases, and then only in the hands of well-qualified and experienced medical men.

EMOTIONAL CRISES

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What are emotional crises?

Emotional crises is the term used recently by some psychiatrists and psychologists to denote short psychological upsets which occur from time to time as a person wrestles with life problems temporarily beyond his capacity.

Why are psychiatrists interested in emotional crises?

When they analyze the life histories of patients suffering from mental disorders, psychiatrists find that sudden deteriorations in the patients' mental health often occurred following emotional crises. They feel, therefore, that during the crisis periods significant changes in mental functioning must take place. A study of such crises should throw light on the causes of mental disorder and may also suggest opportunities for preventive action.

What is the nature of crisis? How can crises in general be analyzed theoretically?

A crisis may occur in an individual, a small group such as a family, an institution such as a school, or a community. Each of these units or systems is normally in a state of equilibrium as a result of a balance that is maintained among its various internal and external forces. For example, in the functioning of the human body, the chemical composition of the blood and the body temperature are kept steady between certain limits despite alterations in food intake, air temperature, and humidity. This is accomplished by internal adjustments, called homeostatic mechanisms, which counteract external changes, e.g., rise of air temperature is countered by perspiring and by quicker breathing, which lead to more evaporation and greater cooling of the body.

What happens in a crisis is that the homeostatic mechanisms are temporarily unable to maintain the usual balance because of the alteration in the environment, and, therefore, the functioning of the system is upset. This leads to a rise of tension and signs of strain, and also to a

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temporary lowering of the efficiency of the system because its various parts are no longer acting in harmony. The rise of tension usually stimulates new internal adjustive changes and also changes in the relation of the system to its external world. These alterations lead to a new balance between the altered system and its altered environment. The tension and strain subside and a new steady pattern of functioning emerges as the crisis terminates.

If the external circumstances are sufficiently extreme so that no adequate adjustment is possible the system will eventually disintegrate.

What types of crisis have been studied by mental health specialists?

Mental health specialists have used the crisis theory, outlined above, to clarify various manifestations of the behavior of individuals and groups. The specialists originally became interested in the physiologists' descriptions of the steady states manifested by bodily systems and of physiological homeostatic mechanisms. They saw the resemblance between these bodily manifestations and the psychological manifestations of the individual, and began to interest themselves in "intrapsychic" or "emotional" crises.

Mental health specialists also have analyzed crises in small groups, which have been called "interpersonal crises," crises in institutions, which have been termed "social system crises," and crises in communities, which have been called "social or community crises." All these crises seem to have basic elements in common. Moreover, since an individual is a member of a family, which in turn is a subsystem of a community, a crisis in the larger units is likely to upset the functioning of their subsystems so that family crisis, institution crisis, and community crisis may all upset one or more of their member individuals.

Who else besides mental health experts is interested in crises?

Mental health specialists have only in recent years become professionally interested in crises, but others with an interest in various aspects of human existence have focused upon this topic since time immemorial. Poets, dramatists, and novelists have often chosen to portray significant aspects of human nature by depicting individual, family, and community crisis situations. Particular aspects of crisis have had a special appeal because of their dramatic quality. These have included the problematic nature of a crisis situation—the individual faces a situation beyond his control and strives to find a way out; his way is not clear and

he usually tries different abortive solutions before he eventually finds something that works. The mystery or puzzle and its eventual solution arouses the interest of the audience. Also important is the rise of tension to a climax or series of anticlimactic peaks, and its eventual fall. This arouses a sympathetic excitement in members of the audience, who because of the universality of the phenomena, can empathize with the characters of the play or novel.

Another aspect of crises, which has been made much of by dramatists and novelists, is that the rise of tension in individuals and groups stimulates the emergence in them of unexpected strengths and resources. A heroic quality is thus introduced, in which the audience can vicariously participate by identification with the characters.

The participation of the audience is also stimulated by another interesting phenomenon of crises, namely, that as we see tension mounting to a climax when someone struggles with a crisis problem, most of us have a fundamental impulse to help. When we were children, we shouted encouragement and advice to the hero, and we hissed the villain. As adults, our contact with reality inhibits this reaction, but it is probably not too deeply buried, and helps make a good play an experience in which we become personally involved. Analogues of this social response to offer help in a crisis can be seen in many social animals; and the social biologists have described the behavioral signals expressed by distressed animals which appear to call forth this same reaction in other animals.

Political and social scientists, historians, and economists have also been interested in crisis manifestations because a crisis, whether in an individual or in a group, is a period of relatively sudden and sometimes quite drastic change. It is a crucial period when decisions may be taken which may have long-lasting consequences. Factors influencing these decisions may have been present for a long time before the crisis, but many historians believe that the exact form of the decision can only be understood by studying what occurred during the crisis period. At that time a choice was apparently possible between diverging paths, and in order to understand why one was chosen over the other we must analyze the forces at work during the relatively short period of the crisis.

Recently biologists, physicists, chemists, communications engineers, and other physical scientists have also been interesting themselves in theories of crises. The systems that they study consist of patterns of interrelated concrete entities, such as the human body, rather than the patterns of abstract symbols, such as the human personality or the social

life of a community, studied by the social scientists and men of letters. Some mental health specialists believe that the mathematically expressed theories of the physical scientists may one day prove applicable also to the mental health field, especially when electronic computers—mechanical brains—have helped to clarify some of the outstanding technical difficulties inherent in trying to translate the metabolic processes and electrical reactions of brain cells into real bridges to symbolic thinking.

What are the characteristic manifestations of an emotional crisis?

During an emotional crisis an individual's usual pattern of behavior is disorganized. He may appear confused and is less orderly in his thinking about his work and social life; his thinking is not based on reality as much as it formerly was and is more prone than usual to be influenced by fantasies and irrational stereotypes. Because of this he is less effective in his work and his social actions. He becomes preoccupied with the life problems which precipitated the crisis, and he mentally rehearses or actually attempts a variety of responses in an attempt to solve these problems. Incidents from past crises which had something in common with the present one often rise in his memory, and old anxieties and guilt feelings may return once more to hamper his current efforts.

The person in emotional crisis is tense and may be anxious, irritable, guilty, ashamed, hostile, or depressed. During the crisis period these symptoms come and go, but typically the tension rises to a peak or series of peaks, and as it rises the individual shows signs of tension-release such as motor restlessness, fidgeting, and muscle tension. In addition, he is likely to have a defective appetite and difficulty in sleeping, and to show signs of unusual fatigue.

Is an emotional crisis a form of mental disorder?

No, even though the manifestations of emotional crisis resemble some of the symptoms of a mental disorder. It is the sign that the person is actively struggling with a stressful situation. Crises resolve spontaneously. They occur in both mentally healthy and mentally unhealthy people.

Does a crisis always lead to mental disorder or can it sometimes result in better mental health?

A crisis is a potential turning point. It represents not only danger but also opportunity. The change may be for the worse or for the better.

Some people emerge from a crisis or a series of crises with a mental disorder, which represents a more or less stable unhealthy solution for the difficulties of their lives. Others emerge from a crisis emotionally more mature—they have learned new ways of mastering difficulties and are better able to face future problems. Of course, many avoid both the danger and the opportunity and are substantially unchanged by the experience.

How long does an emotional crisis usually last?

The minimal duration of a crisis is a matter of arbitrary decision. Minor problems may produce short periods of upset lasting a few hours, which may be called crises, but it is unlikely that such minor crises have any mental health significance. Most experts feel that crises are of importance for mental health only if they last at least a few days, which means that the life problem was so difficult that it took a relatively long time to work out a suitable solution, and the likelihood is that this solution may have involved some new way of coping with life.

What precipitates a crisis?

The upset is caused when the individual is confronted with an important life problem from which he cannot escape and which he cannot solve in a short time, in his usual way. The source of the problem may be primarily in the environment and due to physical or psychosocial changes, or it may be primarily internal and due to physiological or psychological upheavals, such as the internal changes of puberty, pregnancy, menopause, illness, and old age.

What types of environmental life problems precipitate crises?

There are three main types: (a) the loss of a source of satisfaction of basic needs, such as the death or departure of a loved person; or a loss of bodily integrity, such as a crippling illness or the amputation of a limb; (b) the danger of such a loss; (c) a challenge that overtaxes a person's capacities, such as a sudden job promotion for which he is not adequately prepared.

Will similar life problems precipitate crises in everyone?

No. The situation must be perceived as being important and inescapable, and must be beyond the individual's problem-solving capacity. These issues are influenced by both cultural and individual

factors. The values and traditions of a person's culture will to a large extent determine whether he perceives a certain situation as important or dangerous. They will also determine whether the handling of the situation is a matter for him to work out, or whether there are expected behaviors in the choice of which he has no responsibility.

For instance, in a middle-class Yankee family a situation in which the breadwinning father contracts pulmonary tuberculosis and has to be admitted to a sanitarium is certain to be highly stressful both for him and his family. It will be perceived as endangering his life and his status as head of the family, which is dependent upon his earning a living and being present as an authority in the home. The culture does not prescribe set ways of handling this situation, and the individuals will have to work out their own ways of dealing with it.

The same kind of situation in a lower-class Italian family may well be a different problem. The status of the father as head of the family usually is not dependent upon his making a living or upon his presence in the home. His simple existence as the biological father generally ensures the continuation of his position of respect and authority in the family. Moreover, a religious fatalism is likely to govern the view taken of his life. The way to deal with the danger of death is then clearly prescribed for this family. Prayer for Divine intercession provides a way to seek help; apart from this he and his family are likely to feel there is nothing for them to do but wait for the outcome. Reduced family income oftentimes will be supplemented by friends and relatives or by social agencies, and many previous similar experiences will make this a familiar process. This man and his family, therefore, are not likely to experience crisis in this situation.

Is it possible to make a list of hazardous situations that are likely to precipitate crises in most people?

Yes. In any culture, when we study the reactions of people, we are likely to find typical situations which will precipitate crises in a significant proportion of people. These situations are usually situations of transition or change involving the person and his loved ones—birth, illness, or death in the family, movement to a different living situation, movement to a different social status, for example, promotion at work, alteration of a role such as from fiancé to husband, or from schoolboy to college student.

Apart from cultural factors are there individual factors that determine whether a hazardous situation will precipitate an emotional crisis? Does the person's past experience with hazardous circumstances influence his current reaction? How is his reaction affected by his personality strength and by his current state of physical and mental health?

If a person has successfully mastered similar hazardous circumstances in the past, he is less likely to go into crisis, because he knows what to expect and how to deal with the situation. Even if he can't immediately solve the problem, he knows what steps to take and has a general idea of how much time it will take him to work his way through the difficulty. He also knows what anxieties and frustrations are likely to be involved, and he has the confidence that he can withstand these unpleasant feelings. Under these circumstances any emotional upset he suffers is likely to be localized and not spill over to the generalized disorganization of his life, which constitutes a crisis.

If a person has previously handled similar hazardous circumstances unsuccessfully, he may be especially prone to go into crisis. His past failures may weaken his self-confidence in his current difficulty. He is then more likely to deal unsuccessfully with the current crisis and emerge from it mentally less healthy than before.

The person's current state of physical and mental health is important. If he is physically fatigued or ill, he is more prone to crisis and more likely to resolve the crisis in an unhealthy way. This is also likely if he is burdened already by a mental disorder that prevents him from utilizing effectively his personality strengths.

What is involved in the resolution of a crisis?

During the crisis period the person wrestles with the psychological problems and eventually finds what is for him a new way of dealing with them. Each crisis has its own characteristic tasks that have to be handled. In bereavement, the main tasks are mastering the sense of loneliness, resigning oneself little by little to the reality that the deceased will never again share one's life, and freeing oneself to form new emotional attachments despite the realization that they too may be painfully broken. In the crisis of a mother who has given birth to a premature baby, the tasks include facing the sense of failure at not producing a normal baby, accepting the possibility that the baby may die or be crippled, mastering the deprivation due to being separated from the baby when he has to be left in the premature nursery, pre-

paring for his special needs when he is discharged from the hospital, and readjusting to his eventually becoming a normal robust infant.

Such psychological tasks require mental "work," which we call "crisis work." This work is neither easy nor pleasant; it is fatiguing.

What is the healthy way of resolving a crisis?

The person faces his life problems despite the pain involved, and works out adjustments and adaptations that are in keeping with his culture.

What are the unhealthy ways of resolving a crisis?

The person can avoid doing the crisis work by pretending the problem does not exist or by denying its importance. A bereaved person may pretend that the deceased was not important in his life or even that he is glad to be rid of him; the mother of a premature baby may pretend that there is no danger to his survival or that there is no need for the baby's special care in the first few months.

The person may also use solutions based upon fantasy rather than reality; for example, the bereaved person may operate as though the deceased were still alive.

The person may also end the crisis by developing psychiatric symptoms that preoccupy him or alienate him from the reality world in which the problems exist. The bereaved person may suffer a personality change and mimic the personality traits of the deceased as though to say—"he is not dead, I have not lost him, he continues to live inside me"—or he may develop a psychosomatic illness such as ulcerative colitis in which the mixed feelings about the deceased are transposed into internal bodily changes.

What persons can aid in resolving a crisis?

Those to whom the person in crisis is emotionally attached such as friends and relatives, and also those who have influence on him because of their authority, such as the professional members of the community, for example, doctors, nurses, teachers, clergymen, etc., can aid the individual in resolving a crisis. In addition, there may be other influential people, such as a wise neighbor, the local grocer, drugstore proprietor, or a local bartender, to whom he may turn for help because he respects their wisdom or knowledge of the world.

Is a person in crisis especially amenable to help from others?

Yes. As the tension rises, the individual in crisis seeks help more readily, and during the period of imbalance a little help will have a big influence on him. He is off balance and a minor force may push him down to one side or the other. The same force would have very little effect if he were in stable equilibrium. These forces produce results similar to the effects of pushing a man who is standing on one leg as compared with pushing him when he is firmly placed on both legs.

What is the significance of intervention in preventing mental disorder?

Intervention during a crisis may significantly benefit the person's mental health by ensuring a healthy resolution of the crisis. It is a way of getting maximum results with minimal effort. Intervention need not be restricted to mental health specialists, who will always be relatively few in number, but can be accomplished also by all the other influential persons who may be in contact with people in crisis. In this way preventive efforts may be spread widely in the community and may reach many people at crucial times in their lives.

What kinds of preventive services are used?

a) Preventive intervention by psychiatrists, psychologists, or psychiatric social workers with individuals in crisis and their families. This is carried out in community situations where we are likely to find a significant number of people in crisis because of predictable hazards, for example, prenatal and well-baby clinics; tuberculosis clinics; surgical wards in general hospitals; admission services of kindergartens, schools, and colleges; professional training programs.

The intervention may be conducted on an individual basis or with groups of people facing similar crises. Predictable crises such as those precipitated by surgical operations, parenthood, college entry, etc., may also be handled by anticipatory guidance in which the specialist helps the people rehearse ahead of time the emotional situations in which they are likely to find themselves, and begin to work out in advance how they may be able to cope with their difficulties.

b) Special education and training of the care-giving professionals (doctors, nurses, teachers, clergymen) so that they may intervene more effectively in the crises of their clients as part of their everyday professional work.

c) Consultation by the mental health specialists with the care-giving

professionals when the latter run into technical problems while intervening in the crises of their clients.

d) Public education so that people in general may learn more about crises and how to deal effectively with them in order that they may know how to help members of their family in the event of crisis, and perhaps also know how to help themselves when they are in crisis. The latter will probably not be very effective, however, because the intellectual knowledge derived from public education is not likely to be remembered during the emotional upset and confusion involved when a person goes into crisis. It is much easier to help someone else who is upset than to remember what to do when you yourself are off balance.

Has the crisis concept any application in programs for treatment and rehabilitation of mental disorders? Has it any application in the general health and welfare fields?

Yes. All people feel more in need of help during the upset of a crisis and at that time are more eager to collaborate with professional people and agencies. Moreover, they are also more susceptible to influence at such times. A tremendous saving in professional time and money, and a significant improvement in results would occur if all community agencies altered their administrative arrangements to capitalize on this knowledge, that is, to extend remedial effort during crisis periods in the lives of individuals and families, rather than making clients wait for professional treatment until they had dealt unaided with their crises, and had settled down to a stable state resistant to change.

Does a similar principle hold in the field of community organization and social action?

Yes. This is well recognized by politicians who prefer to expend their efforts to change the attitudes of populations during periods of community crisis, and even sometimes artificially stir up crisis with this end in mind. Professional workers in community mental health do not need to copy the techniques of the politicians, but they may well pay attention to some of the principles underlying their operations.

What are the general signs of unhealthy adjustment patterns?

People who emerge from a crisis with worsened mental health usually show a number of the following characteristics in their ways of dealing with their problems:

a) They do not actively investigate the problem situation, and consistently avoid it or deny its hazards. Their judgments are not based upon an appraisal of the realities of the situation, but upon wish-fulfilling or fear-arousing fantasies.

b) They avoid and deny negative feelings. If these feelings break through, they deal with them by projection, that is, by blaming others for their troubles.

c) If the denial and avoidance do not work, they suffer a massive and generalized disorganization of functioning that involves most areas of routine living.

d) They cannot "pace themselves" adequately. They do not handle their own fatigue well. Either they wear themselves out, or they rest all the time.

e) They do not seek help from others, or if it is offered they cannot accept it.

f) They react to their problems in stereotyped ways and easily feel overwhelmed.

What research has been carried out on emotional crises?

Studies have been made of the psychological reactions of bereaved persons, of the parents of premature babies, of the impact of tuberculosis on a family, of patients in a general surgical ward, of women undergoing hysterectomy, of the parents of children entering kindergarten, of women during the crises of pregnancy, of students during transition from high school to college, of people being displaced from their homes by urban relocation programs, and of refugees and immigrants.

Some of these studies have been restricted to analyzing and describing the manifestations of the crisis, that is, the typical internal mental tasks, the external reality problems, and the various ways in which people cope with them. Other studies have related different patterns of dealing with desirable and undesirable outcomes of the crisis in an effort to define healthy and unhealthy adjustment patterns.

What does research teach us about effective or healthy patterns of coping with crisis?

Each crisis has its own characteristic set of internal mental tasks and external reality problems that must be handled in appropriate ways, but the following general ways of reacting seem common to many people who have dealt adequately with various crises:

a) They have actively explored the reality issues and tried to obtain information from many sources so as to build up a realistic understanding of the problems and hazards.

b) They have freely expressed their negative feelings engendered by the crisis and have been willing to put up with the frustrations until they can work out a solution.

c) They have actively sought the help of others in dealing with the problems.

d) They have broken down the problems into manageable bits and worked them through one at a time.

e) They have been aware of their own state of fatigue and have taken adequate rest, so as not to wear themselves out. Although they have shown some disorganization, especially at times of peak tension, they have managed on the whole to maintain their integrity and control in many areas of routine activities.

f) They have actively tried to master certain issues and control certain feelings, and, on the other hand, have been willing to resign themselves to accept the inevitable in other issues. There is a flexibility and willingness to change in the face of new perceptions.

g) They have a basic trust in themselves and others, and a basic hope that they will come through the crisis relatively intact despite the inevitable sufferings and frustrations.

EMOTIONAL MATURITY

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What is the definition of emotional maturity?

Emotional maturity is often thought of as an ideal state toward which, like truth and beauty and goodness, one aspires and can perhaps approximate, but seldom achieve. It is more useful, however, to think of emotional maturity as a process rather than as a state. This process has its counterpart in the biological concept of "maturation."

As long ago as 1926 Adolf Meyer, who for a generation was the intellectual leader of American psychiatry, said that there were two approaches to mental health—the Utopian and the scientific. The same might be said of emotional maturity, which in many respects is a concept similar to that of mental health. The Utopian approach, Meyer believed, leads to moralizing, and the scientific approach, to experimentation and action. It is the latter that should concern us most. This does not mean that one should belittle any statement of ideal goals, however remote or difficult to reach. But the definition of emotional maturity must remain somewhat vague, elusive, and ambiguous, and in any case, definitions themselves do not solve problems. They should, however, help us toward operational procedures leading to solutions.

From what does our concept of emotional maturity derive?

It derives from the experiences that men have had in life and from statements about human conduct made by philosophers, leaders of society, and more recently, by anthropologists, psychiatrists, psychologists, and sociologists. All of these people are concerned with human behavior, growth, and development, and all have contributed to our present concept of emotional maturity from a scientific rather than a moralistic point of view. The observations of psychoanalysts and of child psychiatrists have been of particular importance in determining our present concepts of emotional maturity.

Does emotional maturity in this country differ from that of other countries? If so, why?

The answer to this question is, "Yes," because the concept of emotional maturity can never be separated from the cultural norms of any community. It is not, for example, evidence of immaturity for an Italian family to remain together as a closely knit unit, whereas in the United States, it is at present considered normal, healthy, and emotionally mature for the young adults to move out of the family circle and to set up their own homes, perhaps preferably at a distance. It would not be considered emotionally mature for a young American adult, male or female, to continue living with his mother and remaining unwed, whereas in Ireland this is frequently the accepted pattern of behavior. It would not be considered emotionally mature for a young American girl to go into a serious depression, perhaps a suicidal depression, because her family failed to provide her with a trousseau preparatory to marriage, and yet this fact once led a young Sicilian girl to just such an understandable, if desperate, maneuver. It would certainly not be emotionally mature for an American servant to plunge a knife into his abdomen because his employer had criticized him for slovenly work, and yet at one time this was the accepted pattern in Japan. It would not be emotionally mature in the United States for a husband to take to his bed while his wife was in labor, but such practices are familiar in certain parts of the world and are not looked upon askance.

One could multiply such examples *ad infinitum*. What they emphasize is the fact that such concepts as mental health and emotional maturity are relative ones, always conditional upon the culture in which the individuals live and upon the traditions, the habits, and the values of such a culture.

What would indicate that an individual is emotionally mature?

Since we are approaching the subject of emotional maturity more from the operational point of view than from the ideal and moralistic one, the answer to this question depends on what the individual is capable of doing. First, is he able to plan for the future? Can he wait for his satisfactions to come in due course or does he insist on immediate gratification? In other words, can he tolerate a reasonable degree of frustration, and is he flexible enough and adaptable enough to change his attitude in order to conform with the exigencies of life?

(A mature person should be able to do all these things without loss of self-control and without excessive display of emotion.) And, furthermore, can he behave in this adult fashion, even if he has himself well in hand, without too much strain and without developing too much anxiety?

In our culture an adult is supposed to be independent, that is, he no longer should depend on others for his livelihood or his existence. Moreover, he is supposed to be ready to care for others and not be concerned chiefly with being taken care of himself, nor should he expect to be taken care of. These are, perhaps, the minimal criteria which indicate an individual's emotional maturity. Is he able to take care of himself, and this means economically and socially (from the point of view of his occupation), and is he able to take care of younger and less mature individuals? Can he be a parent without too much strain—without too much anxiety, without too much irritability, depression, or hostility, all of which are evidences of strain? And can he perform these functions with satisfaction, with zest, even with pleasure—at least a moderate part of the time?

Sigmund Freud once stated that the essentials of mental health were to be able to love and to work. Nobody has, perhaps, surpassed this definition and certainly the indications of an individual's emotional maturity would include these—the capacity to get and to give satisfaction in a love relationship, and also in one's occupation.

On the other hand, one must bear in mind that psychological maturity cannot be measured by any single isolated trait in a person, but is measured by his total character structure. Perhaps it is impossible to treat psychological maturity as a scientific idea devoid of judgmental values. One would need to know a great deal about an individual's capacity to establish good relationships with others before one would have any sound criteria for judging his emotional maturity, and one would need to know something of the bonds that tie him mentally, emotionally, and socially to his fellowman. These, of course, will depend upon his knowledge, his sense of responsibility, his ability to communicate, his sexual life, his general capacity for empathy, and on his philosophical approach to himself and to his world as well. We have no quantitative measurements for estimating a person's state of maturity, but we know something about the norms of human behavior, which in this instance must take into consideration, above all, the individual's adaptability and tolerance of frustration, and his relationship with others.

What attitudes would indicate an individual's lack of emotional maturity?

Lack of emotional maturity is indicated by: inability to plan for the future; insistence on immediate gratification of wishes and desires accompanied by imperious demands on other persons, plus a tendency to manipulate them for one's own purposes; excessive and inappropriate display of emotion in the form of tears and temper tantrums on slight provocation; excessive and prolonged dependence with more concern for being taken care of than for caring for others; and disturbed love relationships characterized by ambivalence, that is, contamination of love feelings with hate, and love strivings directed more toward the immature person himself than toward others, or so-called narcissistic love.

Maturity is not simply the opposite of immaturity. We shall probably not arrive at a sound understanding of maturity if we proceed by describing an immature individual and then by saying a mature man is everything that this one is not. Good is not simply the opposite of evil. Peace is not simply the opposite of war, and health is not simply the opposite of illness. Such conceptions as good, peace, health, and maturity are holistic (pertaining to the doctrine that a living being has properties that pertain to the whole rather than to its parts), are inclusive, and this very fact is what makes them so difficult to define in scientific terms. The methods of science are analytical and, in general, its tools are not those that lead to synthesis. To describe the whole we must fall back upon the language of the artist and the poet who by their art can interpret and re-create what they observe and thus make the whole come to life again.

Is emotional maturity more difficult to attain in today's living than it was twenty, fifty, or a hundred years ago? If so, why?

I cannot answer this question in a yes or no manner. Let us consider some of the changes that have occurred in our society during this period: the great and rapid increase in population; the urbanization of our civilization and its attendant crowding and competitiveness; the greatly increased life expectancy in the early years; the virtual disappearance of child labor; the universality of education even through the high school years; the migratory life of many families, involving frequent changes of abode and changes of school; and the increased social mobility as well, with the result that a farmer's son

may become a bank president and a coal miner's son, a great movie actor.

It would seem that contemporary life makes greater demands on an individual's flexibility and adaptability than the relatively stable, secure, and predictable society of the past. The family is no longer an economically self-sufficient unity. Its ties have accordingly been loosened, and parents have lost much of their authority. The models that they once provided for their young are no longer as absolute as they once were. It is no wonder that young people today are often confused as to occupational roles and also as to sexual roles and so have difficulty growing up. It is far easier for a boy, for example, to identify with a father who is a hunter or a fisherman or a farmer, whose work a boy can observe and understand, than it is for a son to identify with a father who is a stockbroker or a psychiatrist. A boy whose father is in the second group may lack a kind of occupational model and such models, of course, facilitate growth and development and eventual maturity.

Likewise, the change of status of women, who more and more compete with men, and leave their homes in order to earn money, probably leads to a disturbance of the occupational and sexual models of young girls and also, for that matter, of boys. Families are smaller than they were, and parents are perhaps more cautious and protective of their children—and they expect them all to survive. Perhaps they cling to them more tenaciously and thus keep them from growing up. This was probably not so common when there was always another baby at home on whom to expend mother love.

But on the positive side, the improvement in hygiene and the release from drudgery perhaps facilitate the attainment of emotional maturity. If a person has severe rickets as a child (which was so common a hundred years ago), if he is anemic or has dietary deficiencies or contracts tuberculosis or other communicable diseases (for which, fifty or a hundred years ago, little could be done), then emotional maturity could not easily develop out of such handicaps.

The new knowledge and increased awareness of the emotional needs of infants and small children are as important as all of the advances in hygiene. These needs we have learned to take seriously and to treat with a respect unheard of in past generations. For the small infant they can be met only by its mother, or a substitute for her, and on this relationship between mother and child much of the offspring's future emotional health will depend. Neglect or lack of warmth and

affection can have a stultifying effect on the maturing process; so can overprotection and the mother's own neurotic need to keep her child from growing up and from becoming independent of her.

Do individuals differ in their capacity for emotional maturity? In what way? Do men differ from women in this capacity?

The answer to this question is that they do differ. Some individuals find it extremely difficult to cast off the patterns of childhood, to give up their dependence, and to assume the responsibilities of adulthood. There are types of persons who have what appear to be excessive dependent needs, and if these needs are unsatisfied, as often they must be, this seems to interfere with the person's subsequent growth. Apparently they require a constant feeling of being cared for; it is very difficult for these persons to venture forth into the world. The reason why this difference between individuals exists is not wholly clear, but we can see within the first months and years of life this very quality become conspicuous in one child and not in another. One child will become bold, adventurous, ready to explore, leave his mother and go to nursery school without tears, while another child will find it extremely difficult to leave his mother. One child will sleep through the night, and the other one will have night terrors that bring his mother to his bedside. It is possible that some of these differences are genetically, if not constitutionally, determined. In any case, they may make their appearance very early in life. From our present knowledge, we can be fairly certain that the way an infant is handled in the first few months' and years of his life has a determining effect on his subsequent capacity for emotional maturity.

One cannot make a categorical statement about the difference between men and women in this except to say that in our culture (which, up to now, has been predominantly a masculine one) it is assumed that women are more dependent. This, however, is probably not true, and the capacity for emotional maturity would not seem to be sex-linked.

Does emotional maturity alter in the aging process?

The process of maturing does not take place at a steady rate and is not consistently progressive. One can expect to find periods of progression and retrogression, depending upon the exigencies of a person's life situation and his state of emotional balance or health. Many people,

as they pass mid-life, find the loss of their powers—intellectual, physical, and sexual—so disturbing that they tend to regress and not to live out their potentialities, whereas other people continue to grow and to mature well into old age. Some individuals tolerate physical disability far better than others, as a result of a natural hardihood or a habitually hopeful attitude or because they are more adaptable and resilient, whereas others are defeated by the first obstacle in their path. As physical deterioration progresses with advancing years, one can expect some mental deterioration and, in the last decades of life, a tendency toward emotional regression.

Is emotional maturity a sign of high intelligence?

Not of itself. One could say that a person of borderline intelligence is seldom capable of achieving emotional maturity, but even in the genius class of intelligence there are many people who have never succeeded in attaining anything even resembling emotional maturity. An intelligence adequate to deal with the facts of life in a realistic way would seem a prerequisite, but beyond that one cannot say that high intelligence is a necessary factor in the development of emotional maturity.

Is the capacity for emotional maturity inherited? Can it be developed in early childhood? Can education produce it?

Emotional maturity, as such, is certainly not inherited. But much that goes into a person's total character—temperament, disposition, and intelligence, as well as physique—is inherited, and all of these factors indirectly affect emotional maturity.

Obviously, a child cannot achieve emotional maturity in the adult sense of the word. He can achieve the maturity that is consistent with his age and with his capacity. The basic elements on which emotional maturity is built are laid down in early childhood, beginning, perhaps, with trust. If such elements are not developed, there is little likelihood that emotional maturity can be achieved without later help, and by no means always even with that help.

Can it be cultivated? Let us say it can be facilitated through experience, through suffering, through training in introspection, and through a kind of rigorous honesty with oneself. The possession of a sense of humor is perhaps the greatest catalyst.

Can education produce it? The answer depends upon the kind of

education. It is doubtful whether a purely intellectual approach to the problems of life can produce emotional maturity. To be sure, the more knowledge we have, the better. But more important than knowledge is a sense of comfort, of security, of trust, which can be instilled early in life through the attitude of elders, especially of parents, toward the child. And these can contribute enormously to emotional maturity. But taking courses and reading books, unless they somehow light a fire in the student, will be less effective for most than contact with a moving and meaningful personality. And even when the childhood has been severely deprived, later enriching encounters can have an almost miraculous influence.

Are there tests that indicate an individual's emotional maturity? What are they? Where are they given? Why are they given?

Yes, there are such tests as the Bellevue-Wechsler Test, which measure not only intelligence but also the ability to reason and to handle abstractions. Both of these are presumptive evidence of maturity. There are also the so-called projective tests, which can give us a great deal of insight into the individual's mental health and also into his emotional maturity. These tests, administered by qualified psychologists, are of great variety, but perhaps the two most familiar ones are the Rorschach, or inkblot test, and the T.A.T., or Thematic Apperception Test.

The Rorschach presents the individual with ten cards consisting of standardized inkblots, such as children make by folding a piece of paper over a blot of ink. The resulting configuration, which is an unstructured form, is then shown to the individual, who is asked to describe what he sees in it. Since the blot is unstructured, what the individual sees in it is what is in his own mind. The way he deals with this material will reveal a great deal about his own preoccupations. It will, moreover, give evidence of the presence of anxiety, of a tendency to resort to the denial of reality, or its distortion, and will tell us something about his capacity for creative imagination. We can also learn something about his major instinctive drives and how he is dealing with them. Such information will be of great value in assessing his state of mental and emotional development.

The second test, the Thematic Apperception Test, has a similar kind of purpose, but here the individual is shown a series of quite provocative pictures and is asked to give a story about what he sees.

Again the story is usually an expression of his own inner situation—his fears, his wishes, his ambitions, his tendency to distort and to fabricate, and this, too, leads to some estimate of the person's mental health and maturity.

There are many other tests, some of them designed to detect anxiety, or to detect preferences with respect to occupational, sexual, or social roles. These tests are often given at the request of psychiatrists or educators who want more information about the character or capacities of the person whom they are trying to treat or to educate.

Can an individual put on an appearance of being emotionally mature, yet actually be emotionally immature? Might this be detrimental to the individual?

It is safe to say that all of us assume certain outer characteristics that make us appear to be more emotionally mature than we actually are. Obviously we do not want to expose our dependency, our insecurity, our anxiety for the public to see; we want to keep these well hidden from colleagues, even from those nearest and dearest to us, if not from ourselves. It should be borne in mind that emotional maturity is not a state; it is not a final condition; it is an ever-changing process that waxes and wanes as we go through life. None of us is proud of the immature parts of ourselves. We try to conceal these or to convert them into something that seems socially more acceptable. Actually, the emotionally immature part of each of us is often of great value since it has a capacity for changing and for growing. Even the most mature individual, if he doesn't retain some childishness, some naïve curiosity, some capacity for play and for fantasy, is a pretty dull person. We all retain a large portion of immaturity, but this in itself is not necessarily detrimental. It could be so, however, if the individual fools himself, if he spends too much energy in denying those immature elements instead of facing them and trying to deal with them in a realistic and constructive way.

What causes emotional immaturity?

This question should be: What interferes with the development of emotional maturity? One cannot answer exactly, because this deals with the whole development of the personality, and one cannot enumerate all the forces that cause a personality to develop as it does. Emotional maturity is the result of many influences affecting a given constitution. The organism responds to the demands and pressures of

the outer environment and its responses in turn alter the demands and pressures acting upon it. Paramount among these demands and pressures are the attitudes and relationships established early in life between the individual and his parents, especially his mother. It is probably true that the people who are emotionally immature and remain so have not had a sufficiently loving and trusting relationship early in life so that they do not quite dare risk the dangers that the outer world seems to present to them. To be sure, nobody's childhood is perfect in this respect and if it had excessive trust and understanding, this might interfere with one's capacity for taking life as it comes with all its vicissitudes and miseries. There is no royal road to emotional maturity, and the best that we can hope for is to provide an infant with a relationship that is so trustworthy and relatively so secure that he is willing and able to separate himself from this state of security and gradually to venture forth on his own.

Can emotional immaturity be a symptom of another disorder? Can it be the cause of another disorder?

Yes, of course. It could be a symptom of any kind of threat, physical or psychological, to the individual. A child who does not develop physically, who is puny, who cannot compete with his contemporaries, might easily remain emotionally immature. A child whose brain has been damaged by an accident or a disease would probably not develop into an emotionally mature individual. Further, emotional immaturity might be a symptom of some profound psychiatric disorder, such as schizophrenia, or it might represent the individual's response to feeblemindedness and to his inability to cope with his environment. But most important, of course, are the psychoneuroses. Such disturbances as hysteria, obsessive-compulsive reactions, and various anxiety states are in some respects the clinical manifestations of emotional immaturity.

Emotional immaturity can be a major contributing cause of many social ills, among them alcoholism, bigamy, delinquency, divorce, drug addiction, gambling, homicide, perversion, prostitution, robbery, suicide, vagrancy, and war.

In what ways can emotional immaturity be limiting to the individual? Be protective to the individual?

The answer to these questions seems implicit in what has already been said. Insofar as emotional immaturity interferes with adult func-

tioning, for example, with procreation, or with care of the coming generation, or with success and achievement in one's professional life, or with gratifying relations with one's fellowman, or with playing a significant role in one's community, it is, of course, seriously limiting. However it can protect the individual within limits against some of the dangers of confrontation and conflict with others and with his environment, but such protection is too dearly bought.

How does one gain emotional maturity through psychotherapy, psychoanalysis, or other therapies? Are these successful methods? On what does their success depend?

If one can gain emotional maturity or, let us say, approximate emotional maturity through psychotherapy, this is accomplished primarily through two ways. First, by establishing a relationship with the therapist that has within it many of the seeds of discontent which have interfered with the patient's growth. By reviewing this material and, above all, by reliving it emotionally, a kind of corrective experience can result. Insofar as the patient and therapist establish a good and trusting working relationship, this in itself can be of enormous value to a patient who has not developed as he could have.

A successful psychotherapy should make it more possible for the person to face up to his reality, to accept it, to accept his own limitations, to accept even his own excessive dependent needs and to look for their satisfaction in real life rather than in some fantasy situation. It should, moreover, make him more tolerant of the limitations of others and less demanding of perfection in them. But, above all, the establishment of a trusting relationship with another individual to whom one is willing to expose one's own weaknesses is in itself of much therapeutic value.

What has been said of psychotherapy can also be said of psychoanalysis, but psychoanalysis is a more rigorous technique, which requires a high degree of motivation on the part of the patient and a willingness to change. Unless he is suffering from his emotional immaturity, it is unlikely that he will submit to the pain of self-revelation and the ignominy attendant on facing himself. In addition, unless he possesses a certain degree of what is called ego strength and a capacity to synthesize the various elements in himself that interfere with his progress, he may not be a suitable subject for analysis. This is a matter of clinical judgment. (See *Ego*)

As for other therapies, certainly the most usual are psychotherapy

in the form of an interview or psychoanalysis in the form of analysis of the transference and of interpretation of unconscious processes. Suggestion is a valuable therapeutic tool in both of these and is certainly an implicit part of psychotherapy. The other current therapies in psychiatry, such as the use of shock treatment or the use of drugs, will not of themselves—without accompanying psychotherapy—lead to the development of emotional maturity, and there is no reason to think that they can replace the understanding and enriching influences that derive from relationship therapy. One should not forget the possibilities of group therapy, play therapy, or even psychodrama, but these are all different aspects under the general rubric of psychotherapy. Success in all therapies depends upon the capacity of the individual to change, his wish to change, his intelligence, and also on the skill, subtlety, and sensitivity of the therapist.

How does one gain emotional maturity through introspection? Is this a successful method? On what does its success depend?

Few people are capable of rigorously honest introspection, partly because of lack of talent, but especially for lack of discipline. But even if a person has the gift for, and some training in, introspection, it is not easy to estimate its value as a method toward gaining emotional maturity. The practice of honest introspection should be part of everyone's equipment in dealing with life. As Socrates said: "The unexamined life is not worth living." It would seem natural for the mature mind to examine itself. Success will depend greatly on the kind of personality, one's accustomed defenses against anxiety, one's need to maintain self-esteem even by self-deception, and one's willingness to look into one's more hidden motives. There is little in our present form of education that leads to successful introspection, but it is perhaps a necessary ingredient of all mature persons.

Can one gain emotional maturity through the daily experiences of living and growing?

Yes, of course, and in a sense only thus. It is the rocky, not the royal, road to emotional maturity. Unless one is willing to face life with all its disappointments, frustrations, joys, sorrows, anguish, and vicissitudes, one cannot expect to develop into an emotionally mature individual. Maturation, which is a process and not a state, depends above all upon facing the existential reality of our lives and somehow coming to terms with it and with ourselves.

Can one wish for emotional immaturity without being aware of the wish for it, and if so, will this tend to perpetuate the state?

Inasmuch as emotional immaturity is an abstraction, one doesn't wish for it. What one wishes for are certain childish things. We may wish to be taken care of; we may wish to be comfortable; we may wish to achieve wealth or fame or success without making an effort to attain them; we may wish to avoid responsibility; we may wish to express our feelings without regard for the feelings of others; we may wish to eat all the time; we may wish to be cruel. All of these are evidences of immature wishes, and we all share such wishes. The question is, to what extent do they dominate our more rational, sophisticated, and adaptive modes of behavior. That these wishes are held by everyone is clear enough, but in some people they do not register consciously in their minds but rather express themselves through behavior or through the development of symptoms. Insofar as these wishes are intense and are rigidly held, they can, of course, in a sense perpetuate themselves and interfere with the development of more adult wishes.

Can the acquiring of emotional maturity be painful?

Not only can it be painful, it is. It is far more painful to realize one's defects and to give up childish things, than to walk blandly and ignorantly in a false paradise; but the very fact of the pain and the willingness to experience it for one's greater good is part of the tempering process of becoming mature. As George Bernard Shaw's Major Barbara said: "Every time we learn something, we feel that we have lost something." And the learning of mature ways is often experienced as another painful loss.

Can emotional maturity be lost through experiencing a painful emotion?

Again, one must constantly bear in mind that emotional maturity is not a final state. It is a process—a process of growth, a process of development, a process we call maturation, and this takes place not at a steady rate but in steps. Sometimes these steps lead backward, but throughout life one should expect some progression in this process. A painful emotion, such as grief or hatred or envy can, to be sure, lead to further maturity if the individual is able to accept it, to transcend it, and to go on to a less primitive and more complicated method of adaptation. On the other hand, such experiences can interfere with

progress and lead to regressive behavior or to a temporary retreat to an earlier mode of adaptation.

What are the significant areas of current research into emotional maturity?

The most significant areas are to be found in the studies of anthropologists and sociologists, and in their observations on growth and development in different cultures as compared with our own. Inquiries into the mother-child relationship, and the effects of separation and grief on the development of a maturing organism represent a significant area of research; and so, too, do some of the observations on early manifestations of psychosomatic disorders, many of which seem to have their origin in early life. Investigations into the sexual mores of contemporary society have also cast some light on this important aspect of emotional maturity. In the same way that much of our information about mental health has come from the study of the mentally ill, some of our concepts about emotional maturity, too, have been established by the exploration of those individuals who remain relatively immature.

What can be said of the future in view of man's state of emotional maturity?

Man possesses the knowledge and the skill to do away with most of the ills that beset him, but his irrational stubbornness, his unwillingness to look facts in the face, his need to deny unpleasantness and to project blame on others may lead him blindly on a course of destruction. These are all attributes of his immaturity. He clings anachronistically to outworn shibboleths that give him a feeling of momentary comfort. But it is not beyond possibility for him to put childish things behind him and to live a full life without terror.

EMOTIONS

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What is an emotion?

In Howard Warren's *Dictionary of Psychology,* emotion has been defined as a "total state of consciousness involving a distinctive feeling tone and a characteristic trend of activity." This is a rather general definition which leaves us wondering if there could be a partial, as well as a total, state of consciousness. It uses "feeling tone" to explain emotion, yet feeling tones themselves are emotional in nature. Another definition by Sigmund Freud considers emotion as the conscious "affect charge" of instinctive forces. This would mean that every emotion needs an instinct to produce it. Yet fear (or anxiety in Freud's term) is not instinctual in origin but is experienced by the ego, according to Freud's system.

For most behaviorists, emotions are changes in reflex strength (B. F. Skinner), or an increase and decrease in drive strength (Clark Hull). O. H. Mowrer, a behaviorist who deviates somewhat from the orthodox view, has considered emotion as a "subjective state" that becomes conditioned to the stimulus and leads to action. However, considering emotion merely as a "subjective state" without further describing it does not increase our knowledge of emotion.

The older notion that emotion is a "disorganized state" has been lately revived by D. O. Hebb who considers fear and other unpleasant emotions as a disruption of brain organization. But if such emotions were the symptoms of disorganization, they would be experienced as sheer chaos; instead, they are experienced as recognizable instances of fear or anger or shame, each urging to different actions. When intense, such emotions may disrupt behavior because of their physiological effects, but they are not products or symptoms of disorganization.

A more precise way to define emotion is to consider it as a "felt tendency toward something intuitively assessed as good, favorable, beneficial, or away from something intuitively assessed as unfavorable, harmful, bad." This definition emphasizes that emotion attracts us to something or repels us from it. Love draws us to the beloved, fear impels us

to flee from danger. Every emotion is based on a recognition that a thing or a person affects us in some way, favorably or unfavorably; and it includes an impulse to action. The appraisal that something is good or bad for us here and now is immediate, unwitting, almost automatic. We see a fist lifted to strike, we estimate that it will hit us, and immediately move to avoid the blow. Without our appraisal that the blow will hurt, we would never be impelled to evade it.

A feeling is similarly based on an estimate of good or bad, favorable or unfavorable effects. It is either a feeling of pleasantness or unpleasantness, of pleasure or pain. Pleasantness is simply welcoming the sensing of something that affects us favorably, while unpleasantness is a resistance in sensing something that affects us unfavorably. It does not necessarily include an impulse to action unless it is so unpleasant that action becomes imperative. When unpleasantness increases, it may become pain but will never add up to fear or anger or hate. When pleasantness increases, it may become pleasure but will never become joy or hope or love. Emotion needs an object that attracts or repels; but feeling needs merely a sense experience, e.g., a pleasant fragrance or taste.

What are the various emotions?

Strictly speaking, there are as many emotions as there are things or people that attract or repel us in different ways. However, there are just a few conditions under which something can affect us: it may be good, and we *like* or *love* it; or bad, and we *dislike* it. If we do not have what we like, we *want* or *desire* it. If we have what we like, we feel *joy*. If we dislike something that can easily be avoided, we simply turn away from it; we feel *aversion*. If something we dislike is actually upon us (e.g., when we have suffered a loss), we feel *sorrow* or *sadness*. These emotions are simply *tending* toward or away from something. But what we like may not be easy to obtain, and what we dislike may not be easy to avoid, so that we have to *contend against* difficulties: we *long* or *hope for* something that is difficult to obtain, and feel *hopelessness* or *despair* if the difficulties seem insuperable. We feel *daring* or *courage*, when we estimate that a threat that is difficult to avoid can be overcome. When we realize that such a threat cannot be overcome, and we strenuously want to avoid it, we feel *fear*. But when something we dislike is actually upon us and we feel that it can be overcome, we become *angry*. Longing, daring, fear, and anger are contending emotions; they contend for the thing wanted or against the difficulties in the

way. Both tending and contending emotions can be called basic, for they are responses to a few basic conditions. All other emotions respond to variations in these basic conditions, or are combinations of basic emotions. Jealousy, for instance, combines fear of loss, anger at the rival, longing for affection, all of which may occur in quick succession or alternate repeatedly.

Do basic emotions have similar physical effects?

All basic emotions have characteristic physical effects, but only a few of them have been investigated thus far. Fear is accompanied by a secretion of adrenalin, which produces a general contraction of blood vessels; it raises blood sugar by releasing sugar both from liver and muscles, and retards the utilization of blood sugar by the muscles. This accounts for the general feeling of malaise, the muscular weakness, and finally, exhaustion, that is the standing complaint of anxiety neurotics who suffer from chronic fear. Walter Cannon's notion that fear "energizes" the organism for flight is true only for the first access of sudden fear, and is the result of the strong impulse to flee, not the effect of adrenalin. As soon as adrenalin begins to affect the body, the first feeling of strength gives way to a feeling of profound weakness. This delayed effect explains the exhaustion felt after a narrow escape from danger.

Anger is accompanied by a secretion of noradrenalin, which has effects different from those of adrenalin. Noradrenalin increases blood sugar by releasing sugar from the liver but not from the muscles; it does not retard the utilization of blood sugar by the muscles and so promotes muscular strength. However, extreme anger (which includes both a strong impulse to fight and an access of muscular strength) may lapse into incoordination. Enraged, a man is unable to handle a complicated machine, and may become quite inarticulate with wrath. Both anger and fear promote quick, indiscriminate action but interfere with coordinated action.

On the credit side, there are emotions that have definitely favorable effects. Love, in the sense of outgoing friendliness and affection, has desirable physical effects. The blood flow is unhindered and often accelerated, the muscles have optimal tone, the skin is warm and rosy, and there is a definite feeling of ease and well-being. When continued, these effects create the best possible conditions for physiological functioning.

What is the psychological effect of emotions?

Generally, the psychological effect of emotions is favorable if their physical effect is favorable. Outgoing friendliness and trust enable a man to meet people with a relaxed objectivity that makes it possible for him to choose the right action without being harassed by fear, suspicion, or impatience. Other positive emotions have the same effect: interest, which is a desire to know or to know more about something, makes work easy; hope enables a man to go on when the going becomes difficult. Negative emotions, on the other hand, have unfavorable psychological effects which parallel their physical effects. Sudden fear may enable a man to dodge an approaching car, but it easily becomes panic if the danger is great. And when he is afraid most of the time, he is hampered in his actions because he is unwilling to expose himself to the ordinary hazards of his daily life. Anger may enable a man to sweep away an obstacle; but sudden rage may so blind him that he does things he is sorry for a moment later. When he has a hair-trigger temper, it puts considerable strain on his heart and on the good nature of those around him.

Often the physical effect of emotion becomes an occasion for concern that increases the very symptoms a man is concerned about. If he is afraid without paying attention to his fear (as, for instance, has happened to pilots on bombing missions during the last war), he may notice his weakness, tremor, or fast heart rate, long after the danger is over, and begin to fear he has a serious ailment. Thus he adds fear to fear and eventually is grounded for chronic fatigue.

Is sexual desire an emotion?

Sexual desire, like emotion, is a felt tendency toward something we want or desire. It has an urgency that is akin to emotion, though it has different roots. Basically, sexual desire is an instinctive tendency. Like every such tendency, it is produced by a change in the hormone balance of the body. Sex hormones are poured into the bloodstream and detected by a sensitive area in the brain (the hypothalamus), which excites neural pathways that give rise to felt impulses to action, a restlessness that is often called "sexual tension." At the same time, images of pleasurable situations are aroused which give direction to the urge to action. This instinctive urge, combined with the emotional tendency to pleasurable sexual activity, is the sexual desire.

Is love always accompanied by sexual desire?

Love is an emotion. It depends on the intuitive estimate that one person is valuable to another in a personal way. Love becomes a sentiment when it is deeply felt and fills a man's life, so that everything he thinks or does is done with the beloved in mind. Love can be felt even when the source of the instinctual impulse (sex hormones) is either not yet, or no longer, available. Love and sexual desire may be combined, but it is possible to feel love without sexual desire, or sexual desire without in the least caring for the sex partner.

Since sexual desire is a felt impulse that stems from hormonal secretion but is combined with the attraction to someone emotionally appealing, it is possible to mistake a sexual attraction for love. This will happen when love is romanticized so that the first stirring of an attraction, sensitized by the instinctive impulse, is immediately considered a great love. It is also possible to mistake genuine personal love for sexual desire. When a man's main value is sex, and love is considered an illusion, he may feel a deep and enduring attraction yet refuse to call it love. Only when he is in danger of losing the girl or has actually lost her, may he realize what she means to him.

Are "dream emotions" real emotions?

Dream emotions are real emotions, even though the actions they urge cannot often be carried out. A nightmare is a dream-fear that has become so intense that it wakens the sleeper. Sleepwalking is relatively rare. During sleep, the emotions that have been aroused during the day, or the emotional attitudes that have been acquired, may be touched off by incidental sense experiences (malaise from a heavy meal, sensations of cold or warmth, constriction from bedclothes or noises). Since these experiences cannot be identified during sleep, the dreamer seems to feel them merely as pleasant or unpleasant and then produces dream scenes, guided by his emotional preoccupation, to explain them. Unless a child or adult is afraid or worried about something, he will not have nightmares, though he will dream. Sleepwalking seems to be a similar expression of an emotional preoccupation. The dreamer has an intention or a wish and enacts it in sleepwalking. Or he feels fear and frantic anxiety and vainly attempts to flee or shout for help until he finally does make a sound that wakes him or attracts the attention of his family. (See *Dreams*)

What is the connection between emotion and action?

Emotion always urges to action, but action does not always follow the strongest emotional urge. A diabetic may have a craving for sweets but realizes that he must diet and so refuses to indulge. A youngster away at school may be desperately homesick but hates to admit it and so he decides to stay on. While emotion follows an immediate, almost automatic, appraisal of something as good or bad, favorable or unfavorable, it is the reflective evaluation of this thing and its possible consequences that determines action. When emotion and reflection agree, action becomes easy, almost effortless. The same boy who scorned his mother's efforts to make him presentable becomes meticulous in his grooming almost overnight as soon as he wants to date a girl. Only when emotion is so sudden and intense that it overwhelms a man before he can reflect, does emotion directly lead to action. Normally, there is at least some time for reflection or for recalling habitual standards of action. Of course, a man may habitually indulge in emotion, but even that is a decision resulting from thinking, though that thinking may not have been very reasonable.

How is thinking related to emotion?

Thinking is a cognitive function, that is, it is one of the ways by which we acquire knowledge of the outside world and of ourselves. Emotion is an appetitive function, that is, it is a tendency to action that urges us to obtain what we have assessed as good to have. Emotion is not an isolated experience; it is a link in the sequence from knowing to appraising to wanting and acting. We must first know something before we can want it, and when we want it, we do so because we have found it agreeable in the past or pleasurable right here and now. But we may also reflect on it and then decide whether we want it or not. Often there is a conflict between what is emotionally attractive and what we have decided on reasonable grounds is the desirable thing to do; and often the emotional attraction has the stronger pull, and we persuade ourselves that there is no harm in it. Thus emotion may guide and bias our thinking.

Can certain emotions become habitual?

Emotions may become habitual. Since emotion is an urgent impulse to action, it is always easier to give in to it than to do the reasonable thing. And once a man begins giving in to his emotions indis-

criminately, he is forging bonds that become stronger as time goes on. This is true for both positive and negative emotions. If a man repeatedly gives in to fear, he soon develops an attitude of timidity that makes his life a burden. Another may give in to anger; and the more he does, the more irritable he becomes. Positive emotions also can develop into habitual attitudes. It is as easy to develop an attitude of cheer and hopefulness as it is to develop an attitude of timidity or irritability. But apart from the fortunate few who are always equal to things that may endanger or annoy them, most people have more occasion to "practice" fear and anger. In sober fact, emotional habits do not need to be practiced. The emotion is merely given in to and so creates a disposition to indulge in it more easily the next time.

What might be the far-reaching effects of habitual emotions?

When such emotional habits become fixed, they may become as irresponsible and as harmful as any unbridled natural force. As an example, consider the problem of addiction. A man can become addicted to eating, smoking, reading, to collecting newspapers or doing crossword puzzles; but also to gambling, to drugs, and to alcohol. Of course, alcohol and drugs have additional physiological effects that reinforce the psychological habit and multiply the harmful effects. But in a sense, any addiction is harmful that has acquired such a hold on a man that he becomes unwilling to go counter to it. To break such a habit requires a willingness to suffer the pangs of unfulfilled desire as long as need be, until the addiction is broken. Usually, such a decision needs outside help or a man will not be able to hold out against his ever-renewed craving.

Though an addict may be willing enough to seek psychotherapy, the therapist cannot stay with him twenty-four hours a day until his addiction is broken. For this reason, an association like Alcoholics Anonymous (A.A.) shows more successes than individual psychotherapy. Whenever a new member feels that he has to have a drink, a volunteer from A.A. will stay with him until the craving subsides. In cases of drug addiction, where withdrawal symptoms are severe, hospitalization is usually necessary.

Can emotion cause harmful physical effects?

The felt attraction or repulsion that is the emotion is accompanied by a pattern of physiological changes that are organized toward action.

For each emotion, there is a physiological pattern that remains more or less constant for a given individual. Fear brings about tremor, a racing heart, dry mouth, and clammy hands, with a general malaise that becomes more pronounced the longer the fear lasts. Whether a man is afraid of a bear, a snake, a thunderstorm, atomic war, or financial ruin, his bodily sensations will be similar. They will be more intense the greater he appraises the danger to be, or the more difficulty he experiences in escaping from it.

Behavioristic psychologists often identify emotion with the physical upset that accompanies it. But the emotion comes in full strength as soon as the situation is recognized and appraised, while the physical disturbance takes some time to reach its peak. The physical upset is set off by nerve impulses that must be conducted from the brain to the limbs and viscera; and from there, messages must come back to the brain before the physical changes can be experienced. H. E. Lehmann in Germany, and S. Newman and his associates in the United States, have found repeatedly that an emotion is reported before any physical change can be felt or observed.

Emotions may become physically harmful when they are excessive or long continued. The connection of anger and violent excitement with heart attacks and strokes has been known for a long time; but when there is such an incident, the blood vessels in heart or brain have already been weakened by disease. Normally, it is not strong emotion that is harmful but long-continued emotion. Not every emotion is harmful; indeed, some emotions are definitely beneficial.

What is psychosomatic illness and how is it related to emotions?

Psychosomatic illness is an illness for which no organic cause can be found. A physical illness can be produced in various ways. Ragweed pollen or an injection of Mecholyl (a parasympathomimetic drug) may produce an attack of asthma; but so may acute resentment. In some people, neither pollen alone nor resentment alone will provoke an attack, but both together may do so. In other people, none of these factors, either singly or combined, will produce asthma. In one illness, psychological factors may be negligible; in another illness, of the same patient, they may be all-important.

Psychosomatic illness is produced by the physiological changes that go with emotion. Psychosomatic symptoms can even be produced by paying too much attention to one's physical state. In one of my classes I

had a student who seemed to be continually ill at ease, abstracted, pale, and worried. After this had gone on for some time, I finally asked him what was the matter. It turned out that he had been counting his pulse at every opportunity, ever since a slight accident he had had some weeks before. Every day he found his pulse faster and was by now convinced that he had a serious heart condition. When I told him that he had produced his racing pulse himself by his increasing fear, he was vastly relieved. He again became interested in his studies and soon showed no sign of what could have developed into a full-blown heart neurosis. (See *Psychosomatic Illness*)

There are many other physical disorders that are produced or aggravated by emotional disturbance. Hypertension, gastric disorders (from mild indigestion to perforating ulcers), mucous colitis, headache, can all be caused by an emotional upset or by a continuing emotional disturbance. Even when physical causes alone are responsible for an illness, the patient's emotional state can either aggravate the symptoms or reduce them. Though experts disagree as to the exact way in which psychological difficulties produce various physical disorders and are quite uncertain why sometimes one organ system and sometimes another organ system is affected, there is no doubt that fear, worry, and other negative emotions aggravate the discomfort of any illness; while peace of mind, cheerfulness, and confidence in the physician promote recovery.

Can exaggerated emotions cause mental illness?

Exaggerated emotions do not cause mental illness, though they often occur during such illness. Mental illness or *psychosis* is often accompanied by striking emotional changes. In the first stages of schizophrenia, for instance, the patient often suffers acute anxiety. But it is not the anxiety that causes his illness. Rather, the patient is anxious because the world seems to change before his eyes and he is no longer able to understand others or make them understand him. Later in the course of his illness, he may be completely caught up in the emotions that are aroused by his delusions or hallucinations, and may have little interest and less concern for anything that goes on around him.

Emotions also play a prominent role in manic-depressive illness. During the period of depression, the patient cannot think a cheerful thought; and during the manic phase, everything seems to be a source of happiness and elation. Here also, it is not the emotion that produces the illness but the deranged functioning that gives rise to emotion.

Emotion may not be the cause of mental illness but it is its unfailing companion and not the least of the patient's troubles. In psychiatric treatment, it is not the emotion that is treated but the underlying illness. (See *Psychoses; Manic-Depressive Psychosis*)

There is another type of difficulty, *neurosis,* that is not considered a mental illness but an emotional disorder. Unlike psychosis, neurosis is essentially an exaggerated emotional reaction in which anxiety is the main ingredient. The neurotic has no thought disorder; he is not confused, he has no trouble in recognizing people and things, and he can adequately communicate with others. However, his emotions can bias his judgments and may make it difficult for him to cope with his problems. His fears may be so intense that they incapacitate him for his daily work. In treatment, the psychotherapist attempts to help the patient gain insight into the problems that arouse his exaggerated emotional reactions. When the neurotic succeeds in mastering his problems, his anxiety (and with it the neurosis) is conquered. (See *Neuroses*)

How can we teach children to control their emotions?

The first thing to remember in teaching children to control their emotions is that we do not want to root out emotions. What we want to teach the child is that he should not let his emotions bully him into action. The old adage "to count to ten when angry" has much truth in it. In the time it takes to count, the child may reappraise both the provocation and his impulse to action. Mere counting, however, will not do the trick. He must use the time to reconsider. This will calm him down and help him as well. Some years ago psychologists used to recommend that when a child has a temper tantrum, he should be left alone to cry it out. Leaving the child to cry it out may prevent future temper tantrums, but does not help the child to meet frustrations constructively. He is likely to feel that his parents care nothing for him or his troubles. Of course, it is futile to reason with him while he is sobbing his heart out. But if the mother takes her child in her arms until he calms down, she will find that she can talk to him after his tears have stopped.

More recently, the notion gained ground that perhaps the child should not be frustrated in the first place. However, giving the child what he wants when he wants it does not help him to prepare for the unavoidable frustrations life has in store for him. It is much better to help him acquire self-discipline by accustoming him to a few rules that should be enforced kindly but firmly and consistently. By the time

the child is of school age, he should have learned that temper tantrums do not help him get what he wants. Developing the habit of reconsidering what he wants before clamoring for it will take a much longer time and will require patience and active help.

How can we achieve emotional control?

Since emotions come as soon as something is (unwittingly) appraised as good in some way, the first emotional stirring is never under our control. However, we need not give in to it if reflection shows that the thing that is so attractive is really inadvisable. But if we keep thinking about it and keep dwelling on its attractive features, we allow it to continue its pull and will find it more and more difficult to turn away from it. It is impossible to control emotion by simply deciding to do the right thing. We must also turn our attention to something else that can capture our interest. Emotional control implies thinking, imagining, and finally wanting the things reflection has convinced us are good to have; and turning our attention and imagination away from things that are attractive but, we know, are not particularly good for us.

Control of emotion essentially means making ourselves want to do what we have decided we ought to do. In this undertaking, imagination is of more use than either firm decision or elaborate reasoning. Firm decision is useful mainly in directing our imagination toward what we consider reasonable. And reasoning is useful in finding material for our imagination to work on so that what is reasonable also becomes desirable. Once we have gained facility in directing our imagination toward reasonable things, and follow it up by acting accordingly, emotions become manageable. When fear is countered by courageous action in little things, it soon becomes possible to act courageously in important things, and therefore to develop an attitude of courage and confidence.

EPIDEMIOLOGY OF
MENTAL DISORDERS

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What is epidemiology?

Epidemiology has been called "the study of the mass aspects (incidence, distribution, and control) of disease." The epidemiologist is concerned with the distribution of diseases in time and space. He seeks to establish the rates of illness among particular population groups as related to such characteristics as age, sex, occupation, nutritional status, exposure to various types of risks, etc. Although the methods of epidemiology were originally developed for the study of infectious diseases, they are equally applicable to the study of such disorders as cancer, heart disease, and mental disorders.

What is the purpose of epidemiological studies?

Epidemiological research serves two important functions: (1) by examining differences in disease incidence as related to characteristics of the organism or of its environment, it may provide clues to the complex, often multifactorial causes of diseases; and (2) whether or not causes are known, epidemiological research provides basic information on the needs for disease control and treatment programs within the population. Thus, epidemiological research on pellagra led to the hypothesis that pellagra resulted from a dietary deficiency. Nutritional experiments validated this hypothesis. At the same time, systematic studies of the prevalence of pellagra located the population groups that were subject to the nutritional practices and deficiencies which led to the disease. This permitted the organization of effective control programs. With the control of pellagra, one source of mental disorder was largely eliminated, for psychoses associated with pellagra contributed substantially to mental hospital populations in the states where the disease was most prevalent.

What is the epidemiology of mental disorders?

If we wish to lump together all types of mental disorders, disregarding what we know about their varying causes, it is possible to ask whether one society or one historical period or one racial stock has more mental illness than another. This is a bit like asking whether one society or epoch has more physical illness than another.

Whether differences exist between populations in the total amount of illness or in the extent to which population members are incapacitated by illness may be a matter of general interest. By and large, however, the knowledge will not give us clues to the cause of any particular disease nor will it help much in planning to control diseases. More useful knowledge is gained if we can ascertain variations in the dominant types of disease among populations and the correlates of specific diseases in each. Nevertheless, because mental illnesses have tended to be set off from other types of disorders (and because specific mental disorders are frequently hard to distinguish from one another), a number of epidemiological studies have treated mental illnesses as if they constituted an entity. This has led to attempts to establish whether populations or groups do differ in the total amount of mental disorder. For example, one persistent question asks whether modern urban society tends to produce more mental disorders than did the presumably simpler society in which our forebears lived. Before attempting to summarize the results of such research and of studies that have asked more sharply defined questions about specific mental disorders, however, we shall consider briefly a basic problem of epidemiological research on mental illness.

How are the prevalence and incidence of disease ascertained?

The prevalence of an illness in a given population is the number of cases of that illness existing on a given date relative to the size of the population. The incidence of an illness, on the other hand, is the number of new cases of the illness occurring during a given period of time, again relative to the size of the population. Thus, to ascertain prevalence, one must count all the persons who are ill of the disease at a given time, or at least estimate this number through some sort of systematic and unbiased procedure. It will not help to know that a person was ill last week or last month. One must know whether he was ill on the specified date. To ascertain incidence, on the other hand, one

must know how many people became ill of the disease during a given period—say a given week, month, or year.

When one is dealing with severe infectious diseases, in a population with good medical care (and especially if there is a requirement that physicians report the existence of all cases of the disease), it is often possible to get reasonably complete counts of the number of persons developing the disease within a specified time. It may also be possible to get a reasonably accurate estimate of the number of persons actually under treatment for the disease at a given time, and hence to arrive at an estimate of prevalence. In such instances one would miss cases of the disease which were not serious enough to require a physician's care or which, for some other reason, did not come to the attention of a physician. For some diseases the estimate of incidence or preva- lence based upon treated cases would be a reasonably adequate estimate of the total amount of the disease. For other illnesses, as in the case of milder infectious diseases or of chronic conditions, the estimate of treated illness would be woefully inadequate as an estimate of the total amount of illness. Occasionally, it is possible through the use of surveys employing X-ray or laboratory techniques to screen or examine representative samples of the population and hence to make reasonably accurate estimates of the actual prevalence of a given disease or dis- order in the population. Repeated surveys would, of course, be neces- sary to establish the onset of disease during a given time period, and thus to afford an estimate of incidence.

It is exceedingly difficult to ascertain the true incidence or preva- lence of mental illness. First, there is no guarantee that a mentally ill person will go to see his doctor or that his family will be able to persuade him to undergo treatment. Within Western society, in those regions that are well served by mental hospitals, it appears that a high proportion of persons suffering from the most severe mental illnesses are ultimately hospitalized. However, even in cities with the most developed psychiatric facilities, such as New York, Washington, and London, many persons may be psychotic for months, or even years, before their families manage to get them to treatment, which is usually in a mental hospital.

Thus it is apparent that hospitalization for mental illness affords at best a crude index of the amount of serious mental illness, even in areas with good mental hospital facilities. This crude index may be quite useful for establishing the general characteristics of persons who become severely ill and for determining the history of the disease

process, especially if all segments of the population have approximately equal access to mental hospitals and utilize hospital facilities comparably. Unfortunately, it is always difficult to establish whether these conditions are adequately met, although it is sometimes simple to demonstrate that they are *not* met.

The same limitations apply, of course, to any form of treatment for mental illness. It has long been recognized that statistics relating to treated neuroses cannot be accepted as an indication of the actual prevalence of neurosis in various population groups. Statistics relating to treatment primarily show what segments of the population are both favorably oriented toward psychiatric treatment and are able to afford such treatment.

Even if psychiatric treatment were free, many persons who are mentally ill would not seek such treatment. The symptoms of mental illness often take the form of denying the realities in one's life situation. This includes denying that one needs help of any sort, or that one could appropriately be considered ill. Thus it is unlikely that records of persons receiving treatment for mental illness will ever constitute a completely adequate index of the prevalence or incidence of such illness. Treated cases do reflect relatively intensive study of the patient and hence are a better basis for diagnostic classification than are nontreated cases. It must be acknowledged, however, that at present diagnostic reliability is not high.

Unfortunately, assessments of the mental health status of the population at large or any representative sample of the population are far more difficult, more costly, and less promising in terms of reliability and validity of classification than are population studies to establish the presence of physical diseases. Although several ambitious community studies have attempted to assess the general mental health status of small representative samples of the population, it has not been possible in such surveys to duplicate the diagnostic categories used in more thorough studies of psychopathology. Perhaps the greatest value of such studies, however, is to establish the amount of impairment resulting from mental illness in given populations, and to ascertain the conditions and characteristics associated with such impairment, as well as its relationship to treated mental illness.

It is clear that epidemiological studies of mental illness must deal with many areas of uncertainty and with estimates, sometimes quite crude, rather than with precise measures. Nevertheless, by being aware of the nature of the problems in the data with which they must deal,

and by carefully trying to check their hypotheses and their inferences, research workers in this field have added greatly to our knowledge of mental disorders.

Is mental illness increasing in modern society?

From the time that the first statistics on mental hospital admissions in the United States were kept, until very recently, there has been a constant increase in the proportion of persons hospitalized for mental illness. To a large extent, this increase has paralleled an increase in the number of hospital beds available. However, inasmuch as many hospitals have consistently been overcrowded, it might be argued that additional hospitals have been built in order to accommodate a greater number of mental patients produced by our hectic, industrial society. There is now substantial evidence that the increased pressure on mental hospitals did not represent a real increase in the prevalence of mental illness. A large part of the increase seems to be attributable to the greater use of the mental hospital for short-term treatment of persons who in the past would not have been hospitalized at all, such as alcoholics and neurotics, and for the longer term care of senile and arteriosclerotic persons who, previously, would have been cared for in their homes or in local almshouses, poor farms, etc. (See *Mental Hospitals*)

How does mental illness vary by age-groups?

In general, it may be stated that the most severe mental illnesses —the psychoses—seldom occur before adolescence, and that the probability of being hospitalized for mental illness steadily increases up to about the age of thirty-five or forty, then holds relatively constant to about the age of sixty, and then markedly increases again with advancing years. Up to about the age of forty or forty-five, schizophrenia accounts for by far the largest proportion of severe mental illness. (See *Schizophrenia*) For the next two decades, manic-depressive psychosis and involutional psychosis (a psychotic reaction taking place during the menopause [female] and climacteric [male]), often thought of as the mental illnesses of middle age, make a substantial contribution to the incidence of all mental illness. (See *Middle Age*) Beginning at about the age of fifty, the mental diseases of the aged—senile psychosis and cerebral arteriosclerosis—begin to account for some hospitalizations, and beyond the age of sixty-five they constitute the overwhelmingly dominant types of

mental illness. (See *The Senile Psychoses*) Since about 1950 there has been a pronounced tendency for the diagnosis of schizophrenia to be made more often, and that of manic-depressive psychosis to be made less often than hitherto. This seems, however, to be primarily a reflection of changing diagnostic practices in the United States rather than a true difference in the types of mental disorder found among persons of middle age.

Do the sexes differ in kinds and amount of mental illness?

While the pattern of age differences in rates of mental illness is quite clear, the situation with reference to differences between the sexes is anything but clear. In general, rates of hospitalization for psychosis among males are slightly higher than among females, especially at the younger ages. There are at least two plausible explanations for this differential, however, quite apart from real differences in the frequency with which males and females become mentally ill: (1) males are more likely to manifest aggressive behavior and to be brought to the mental hospital as a result of police action; and (2) to fulfill the normal adult role, a male must be capable of holding a job, while a female may be sustained in the home even if markedly impaired by mental illness. Thus, in general, the difference between the sexes may largely reflect a difference in social response to similar amounts but varied manifestations of mental illness.

There are certain categories of mental illness which do occur much more frequently among men than among women, principally the psychoses associated with alcoholism and with syphilis. (See *Alcoholism*) Both alcoholism and syphilis are, of course, far more prevalent among men than among women, perhaps largely as a consequence of the greater freedom of men in Western culture. On the other hand, involutional psychoses appear to occur somewhat more frequently among women as a sequel to menopause. Again, women are more likely to come into treatment for neuroses, while men are more likely to manifest behavior disorders which lead them into difficulty with the law.

Through the Joint Commission on Mental Illness and Health, a recent effort was made to assess the general adjustment and attitudes toward mental health of a cross section of the American public (*Americans View Their Mental Health*). This study revealed that women are more likely to be introspective and to have a somewhat negative image of themselves. They much more often acknowledged a high degree of

both psychological and physical anxiety; and they more often indicated a readiness to seek help in dealing with their emotional problems. Here again it appears that we deal with cultural patterns which influence both the expression of personality attributes and the social definition of appropriate behaviors.

Are there rural-urban differences in mental illness?

Is life in the city, with its hectic pace, its fragmented social relationships and, for many, its apparent lack of stable moral norms, productive of more mental illness than the more highly ordered round of life on farms or in smaller towns? Apparently not. Although the rates of hospitalization in the largest cities are somewhat higher than those for rural areas, this seems to reflect the drifting of many unstable persons into the largest cities, as well as the greater availability of mental hospital facilities to most urban populations. Surveys of personality adjustment and small-scale psychiatric investigations in rural areas suggest that the frequency of maladjustment and mental disorder there is no less than in the cities.

What effect does mobility have on mental illness?

There is a good deal of evidence that geographical mobility, whether it involves moving from another country, another region, or even another part of the same city or region, is associated with higher rates of mental illness than are found among people who do not change their residences. One type of mental illness, the manifestation of paranoid delusions (delusions of persecution or grandeur), seems to occur quite often among people who move to a country or area in which the native language and customs are different enough from their own so that problems of communication and misunderstanding frequently arise. This has been noted sufficiently often among displaced groups to be referred to as the "alien syndrome." But beyond this and the fact that moving may entail a variety of stresses, the significance of the association between mental illness and migration is not clear. Indeed, the evidence itself, while most often pointing to an association, varies a good deal from place to place.

Persons who are easily upset and disturbed are likely to move more often than those of a more equable temperament. On the other hand, much population mobility derives primarily from economic considerations, and in many instances it appears that it is the most capable

persons who migrate to secure greater opportunities. Thus the reasons for migration and also the amount of stress involved in cutting old ties and undertaking life in a new environment will vary from place to place and from time to time and will vary according to the characteristics of the individual migrants. (See *Mobility and Mental Health*)

Are there racial and nationality differences in mental illness?

Aside from differences in rates of mental illness which are associated with migration and with social status, there is no evidence that the races or nationalities differ appreciably in amounts of mental illness. In comparable life circumstances, it appears that they have comparable amounts of mental illness. This conclusion can be drawn from the systematic, quantitative studies that have been made in the United States, England, Scandinavia, Japan, and Formosa, as well as from the more qualitative assessments that have been made in Africa and among a wide variety of preliterate or primitive peoples. Cultural differences associated with race and nationality seem far more important in their influence on the symptomatic manifestations of mental illness and the social response to it than are the biological correlates of race. (See *Mental Disorders in the United States*)

Is there more mental illness among the poor than among the rich? In the urban slum than in the suburb? Among unskilled laborers than among professionals?

The answer seems to be a qualified "Yes," as regards both hospitalization for severe mental illness and the frequency of reported symptoms of anxiety in surveys of population samples. The most impressive evidence of a differential distribution of mental illness in urban areas came with the ecological (relation to one's environment) analysis of hospitalization for mental illness in Chicago in the 1930's by Robert E. L. Faris and H. Warren Dunham. These investigators found that annual rates of first admission to mental hospitals were much higher for persons living in the central areas of the city than for persons living in outlying areas. This was true not only for persons hospitalized for psychoses resulting from alcoholism and syphilis, but also, notably, for schizophrenia. The distribution of manic-depressive psychoses, on the other hand, was unrelated to the basic ecological pattern of the city. The areas with highest rates of hospitalization for mental illness were areas of physical deterioration, heterogeneity of population, high instability

of population, and low socioeconomic status. Although alcoholics and other deviants often drifted to these areas after they had become deviants, it appeared that many of the schizophrenic patients were indigenous to these areas. Other ecological studies have, in general, confirmed the pattern found in Chicago and have provided evidence that the high rates of schizophrenia do not seem primarily to reflect a drift to slum areas.

Studies of the rates of severe mental illness of occupational groups suggest that persons of higher occupational status, such as professionals and managerial personnel, are less likely to be hospitalized for mental illness, in the United States and England, than are persons of lower status, such as semiskilled and unskilled workers. Scandinavian studies, on the other hand, have found smaller differences in rates of mental illness among occupational groups, except that sailors and domestic workers in major cities have high rates. The latter finding seems clearly to reflect occupational selection, however, rather than to suggest that these occupations lead to mental illness.

In recent years the most influential study of the relationship of social status to mental illness has been that of August B. Hollingshead and Frederick C. Redlich in New Haven. The prevalence of treated psychoses was found to be approximately eight times as high in the lowest of five social class strata (classifications based on area of residence, occupation, and education) as in the upper two strata. In general, treatment for all types of psychoses was inversely related to social status, although affective disorders—manic-depressive and involutional psychoses —showed less difference among the classes than did schizophrenia or senile, alcoholic, and organic psychoses. The higher rates of lower status persons under treatment (largely in mental hospitals) on a given date, however, cannot be interpreted as indicating a more frequent occurrence of mental illness at lower status levels. There was a pronounced tendency for lower status persons to be retained in the mental hospital longer, and thus more would be classified as ill on a given day than would be true for persons of higher social status. Only limited data were available on the incidence of treated psychoses during a specified period of time. These suggest a slightly higher rate of psychoses generally, and of schizophrenia, specifically, at the lowest social stratum than at all other levels but reveal no other clear-cut pattern. Thus, although the data are not wholly conclusive, it does appear that lower social status, and its myriad correlates in terms of living arrangements, family patterns, social deprivation, and possibly a degree of biological selection, does

lead to a greater probability of one's becoming mentally ill. (See *Social Status and Mental Health*)

What effect does heredity have on mental illness?

A major approach in epidemiological inquiry is to examine the frequency of a disease in the families of persons coming into treatment. Are children or brothers and sisters of a patient more likely to develop the disease than are members of the population at large? Are identical twins (the product of the splitting of a single fertilized egg), who share exactly the same genetic makeup, more often jointly afflicted than are fraternal twins (the product of two eggs separately fertilized at the same time)? In such research it would be meaningless to group all types of mental illness, inasmuch as some types may have a hereditary cause and others may not. For a detailed discussion of this topic the reader is referred to the article on *Heredity and Mental Health*. Here we shall merely note that some nervous diseases, such as Huntington's Chorea (a hereditary disease characterized by irregular movements, disturbance of speech, and gradually increasing dementia), occur only in families that have a history of the disease; others, such as schizophrenia and the mental disorders of old age, show a greater frequency of occurrence in previously afflicted families than in the population at large, whereas a number of other mental disorders show no relationship to heredity. An unanswered question in epidemiological studies of mental illness is whether the greater prevalence, and possibly incidence, of psychoses among persons of lowest social status is in part a reflection of a long-term drift of families with a hereditary vulnerability into the lower strata of society. (See *Heredity and Mental Health*)

What developments can be expected in epidemiological studies?

In the past decade research workers in this area have paid much more attention to methodological issues than ever before. They have realized the inadequacy of available techniques for establishing the prevalence and incidence of mental disease and have been working toward the development of more reliable and valid approaches. Data on treated mental illness will probably continue to serve as the basis for a good deal of epidemiological research, but much more attention will be devoted to studying the circumstances under which persons came into treatment. Beyond this, however, a most important development is already well under way—the application of the efforts of re-

search teams consisting of psychiatrists, geneticists, social scientists, and biostatisticians to field surveys of carefully defined populations in order to establish the prevalence of psychological disturbance and problem behaviors relative to significant aspects of life experience. As this encyclopedia goes to press, the researches of Thomas A. C. Rennie, Alexander H. Leighton, and their associates in the United States, and of several teams of investigators in Great Britain are nearing the publication phase. It is hoped that these studies and others now in progress will greatly add to our knowledge.

EPILEPSY AND OTHER PAROXYSMAL DISORDERS

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What are paroxysmal disorders?

Paroxysmal disorders are a diverse group of illnesses that have in common the quality of appearing in episodes which recur at intervals. The symptoms are due to recurrent disturbances in the functioning of the brain and express themselves in a wide variety of ways. Paroxysmal disorders include both epileptic and nonepileptic conditions.

What is epilepsy?

Epilepsy is the term used to describe sudden, recurrent episodes of disturbances in consciousness, or movements of the body, or both, that result from overactivity of irritated brain cells. Changes in consciousness and convulsive movements are its most common symptoms. Epilepsy includes not only the grand mal attack, in which there is sudden unconsciousness with falling and shaking of the limbs, and the petit mal attack, in which there are frequent momentary lapses of awareness, but also episodes involving bizarre automatic behavior, memories, illusory and hallucinatory experiences, and changes in mood.

What is an epileptic convulsion? What is a seizure?

The term "epileptic convulsion" refers to an attack of epilepsy in which there is a violent and involuntary contraction or series of contractions of the muscles. The convulsion is usually accompanied by unconsciousness. The term "seizure" refers to any episode of the numerous manifestations of epilepsy. The term "convulsive disorder" is usually used as a synonym for epilepsy.

What is the history of the care and treatment of epileptics? What has caused the stigma attached to epilepsy?

The earliest treatments were useless and included "driving out the devil" by prayer and exorcism. The first effective treatment of epi-

lepsy was introduced in 1857 when, in discussing a paper at a meeting of the Royal Society of London, Charles S. Locock remarked on his successful treatment of epileptic patients with bromides. Bromides proved very effective and are occasionally used today. After Sir John Hughlings Jackson, at the turn of the century, demonstrated epilepsy to be a recurring overactivity of nerve cells, the search for other compounds began. Bromides remained the only effective compounds for over half a century until phenobarbital was introduced in 1912 by A. Hauptmann. The next great advance in medical treatment occurred in 1937 when the first nonsedative anticonvulsant, diphenylhydantoin (Dilantin), was introduced by H. Houston Merritt and T. J. Putnam. Trimethadione (Tridione) was introduced by W. G. Lennox several years later. These three compounds and their analogues as well as a number of anticonvulsants developed more recently, such as primidone (Mysoline) and ethosuximide (Zarontin) have proved highly useful.

The surgical treatment of local brain damage responsible for epilepsy was attempted for many centuries with poor results. The era of modern neurosurgery began in 1886, when Sir Victor A. Horsley successfully treated a patient for focal seizures. In the past few decades the most notable advances in surgical treatment have come from Wilder Penfield and his colleagues at The Neurological Institute, Montreal, Canada.

Recent advances in the medical control of seizures, in association with a comprehensive approach toward the problems of education, employment, and social acceptance, have brought much new hope to the epileptic.

Owsei Temkin has written a classic history of epilepsy entitled *The Falling Sickness.* Epilepsy was one of the first illnesses to be described. It is remarkable that so much ignorance and superstition still surround this disorder. In about 400 B.C. Hippocrates attacked the primitive notion that the epileptic was possessed by spirits, and he gave excellent descriptions of the epileptic attacks. He poignantly described the reactions of the patient to the social ostracism caused by seizures. "Those who have a premonitory indication of an attack avoid company, going home if they are near enough, or to the loneliest spot they can find so that as few people as possible will see them fall, and they at once wrap their heads up in their coats." Nevertheless, the supernatural origin of seizures was accepted, and writers, from those of the Gospel to the middle of the eighteenth century, still attributed a supernatural basis to epilepsy. The fear and ostracism of individuals with epilepsy today

is undoubtedly in part a carry-over from the unreasonable assumptions and superstitions of ancient times.

How are epileptics classified?

One of the most common methods of classifying epilepsy is by its cause. Epileptics may be divided into two major classes: those in whom a cause can be found, and those in whom a cause cannot be established. Patients in whom no cause can be established or presumed are classified as having "idiopathic" or "essential" epilepsy. Such terms add nothing to our understanding and indicate our ignorance. Patients in whom a cause is discovered or presumed are classified as having "symptomatic" epilepsy. Such patients may have suffered damage to the brain before or during birth. Other causes at any age include irritation of the brain by infections, trauma, tumor, disturbances of blood supply, and degenerative and metabolic diseases. Obviously, in these instances, epilepsy is not a single disease but a symptom. The patients in whom such irritation to the brain has occurred may have any of the various forms of epilepsy decribed in the following paragraphs. This is also true of the individuals in whom no apparent cause can be ascertained. Another method of classifying epilepsy is by the type of seizure the individual displays. This is only partially satisfactory because most patients experience more than one type of seizure.

What are the common types of seizures?

The common forms of seizures are grand mal, petit mal, psychomotor, and focal. There are also a number of other types of epileptic attacks. In the grand mal seizure the patient loses consciousness and then has a convulsion in which there is a tightening of all muscles and usually some jerking movements of the arms and legs. The eyes may roll up, and the individual becomes pale or cyanotic (skin and mucous membranes turn blue) for a short period. Sometimes there is urinary incontinence and biting of the tongue. Afterward the patient is confused and exhausted, and if left alone will often fall into a deep sleep. These seizures involve overactivity of widespread areas of the brain that maintain consciousness and regulate movements of the body.

Petit mal seizures are short episodes of unresponsiveness that generally last less than thirty seconds each and usually occur many times each day. After the interruption in consciousness the individual is mentally clear and able to continue whatever he was doing before the

attack. Petit mal seizures are commonly seen in children and are rare in adults.

The psychomotor seizure has a variety of manifestations but consists essentially of a period of clouding of consciousness during which the patient performs apparently purposeful activity. The individual has no memory of the attack after it is over. During an attack the patient may be unresponsive and merely pick at his clothes or make chewing movements, or he may perform more complicated acts. These seizures usually originate in the temporal lobe of the brain, an area closely associated with the functions of memory, taste, and smell, as well as automatic behavior. Psychomotor seizures are sometimes mistaken for functional psychiatric disorders.

A focal seizure is one in which either the beginning of an attack or the entire attack involves one specific part of the body, such as a limb or part of a limb or the face. Focal attacks involve sensations such as numbness and tingling or may primarily involve movement. Sometimes the overactivity in the limited area of the brain responsible for such localized manifestations spreads to adjacent areas until the entire brain becomes involved, and a typical grand mal seizure occurs.

Many individuals have a warning or an aura that a seizure is about to occur. These auras frequently consist of strange feelings in some part of the body, such as the abdomen, and unusual sounds, sights, odors, tastes, etc. Actually these auras represent the beginning of the seizure and often provide a clue as to where in the brain the seizure originates.

How is epilepsy diagnosed? Where might tests be obtained? Is there a charge?

The diagnosis of epilepsy is in great part based on the description given to the physician of recurring episodes of changes in consciousness and involuntary movements. A person is generally considered to have epilepsy regardless of the cause of the attacks. Some physicians do not use the term epilepsy to describe those seizures that are caused primarily by dysfunction of another organ, which has secondarily affected the brain. An example of this is when overproduction of insulin by the pancreas results in seizures because insufficient sugar is supplied to the brain.

A physical and neurological examination is essential. The electroencephalogram, which records electrical discharges from the brain, helps in confirming the diagnosis in most, but not all, cases, and can

assist in discovering the cause of the attacks. Other laboratory examinations, such as X rays of the skull and studies of chemical constituents of the blood and spinal fluid, are often needed. In every instance it is essential for the neurologist to confirm the diagnosis and to search for a cause. In this way he may treat lesions such as brain tumors, which are present in a small percentage of the cases. In large urban areas both neurologists in private practice and low cost, or free, clinics are available for these diagnostic studies. Patients, in areas where such services are not available, should be referred to the urban centers.

Is there a greater incidence of epilepsy in one of the sexes? In certain national groups? Economic groups? Religious groups? Rural vs. metropolitan groups?

There is a slight preponderance of male patients over females. Of 4,000 patients studied by W. G. Lennox, 55 per cent were male. There is no good evidence for significant differences in the incidence of epilepsy among national groups, races, or religions. There have been no studies concerning the effect of rural versus urban living or of economic status on the incidence of epilepsy.

How many epileptics are there in the United States today? How many are adults? How many are children?

Epilepsy is a relatively common disorder. It is more frequent than tuberculosis and about as prevalent as diabetes. There are no precise statistics on the number of epileptics in the United States. The total number is probably between 639,000 estimated by the epidemiologist, Leonard T. Kurland, and 1,500,000 based on draft board figures of World Wars I and II. Roughly one in every 200 people is an epileptic.

It would appear, according to a report by F. A. Gibbs, that nearly 60 per cent of epileptics are over twenty years of age. However, more than 70 per cent of patients have their first attack before the age of twenty. The highest incidence of onset occurs below the age of five.

Are these rates changing? If so, why?

There are no reliable statistical data on this question. With continued improvement in prenatal and obstetrical care and further control of infections, the actual incidence of epilepsy may be expected to decrease. Two factors that will tend to increase the apparent incidence of epilepsy in the future are an increasing awareness of previously un-

recognized atypical forms of epilepsy and, because of improving social attitudes, a decreasing tendency to hide the diagnosis.

Do these rates differ from those of other countries? Why?

The frequency of seizures in South America may be somewhat greater than that in the United States. This is possibly related to differences in obstetrical practices and parasitic infections. A report from the World Health Organization in 1955 suggested that the incidence in a number of countries throughout the world was similar to that in the United States.

What is the present status of the epileptic in this country in: The community? Social groups? The family? The school? Employment?

People with seizures encounter great difficulty in achieving acceptance into school, community, and social activities. Intelligent community attitudes toward epilepsy lag in comparison to attitudes toward other handicaps. Participation in activities outside the home is often quickly ended by the first public seizure. Patterns of avoiding participation in community and social life develop because of constant rebuffs.

Acceptance into schools varies from community to community. In most large communities, if the general intellectual capacity of the student is satisfactory and the seizures do not frequently disrupt classroom work, children with epilepsy are accepted into the regular elementary and high school programs. During periods when seizures are poorly controlled, a teacher may be required at home. Although the majority of epileptic patients have normal intelligence, there is a small group of children with epilepsy resulting from conditions that also cause mental deficiency. Members of the latter group need placement in special classes. Lennox found that 40 per cent of colleges with enrollments of more than 2,500 students had a policy of accepting students with epilepsy. The percentage of smaller colleges having a policy of accepting students with epilepsy is considerably less.

The usual groundless fears of the epileptic are often quickly overcome by members of his family, who then take on a protective and supportive role. Failure to achieve normal relationships outside the home, however, frequently leads to both overprotection on the part of the family and thwarted desires for independence on the part of the patient.

Although in three-quarters of all cases medication sufficiently controls seizures to allow employment, the problem of obtaining work is

particularly difficult. It has been shown that both the incidence of absence for sickness and the accident rate are generally as low in working epileptics as in other employees. Nevertheless, few corporations have an enlightened employment program for the epileptic. Ohio is the only state where the Workmen's Compensation Law encourages hiring of epileptics by providing financial protection to the employers. The United States Civil Service Commission has a good general approach toward the employment of the epileptic: "With respect to epilepsy as with all physical defects or deviations from the normal, the Commission holds that these conditions alone should not keep a person from being employed in the Federal Service if he is able to perform the duties effectively and without hazard to himself and to others."

What are the causes of epilepsy?

Epilepsy has many causes. The cause of seizures in the majority of cases cannot be established. However, with increasing knowledge and study, greater numbers of patients are now recognized as having symptomatic epilepsy. The most frequent known causes are organic lesions of the brain. Brain lesions occur as the result of prenatal conditions, injuries during the process of birth, trauma occurring later, and infections such as meningitis or encephalitis. Epilepsy caused by diseases involving the blood vessels of the brain or by brain tumors usually begins in adult life. Other causes of epilepsy include inborn and acquired disturbances in the metabolism of sugars, amino acids, and electrolytes. Hereditary predisposition is usually not a major factor in the occurrence of epilepsy.

Are there physical characteristics common to the epileptic?

The patient with epilepsy has no physical characteristics that in any way set him apart from other people.

Are there psychological characteristics common to the epileptic? Are there mental disorders that affect the epileptic in particular?

There are no specific psychological features or personality constellations that are characteristic of epileptics; neither are there specific mental disorders that are peculiar to the epileptic.

The social ostracism and community rejection experienced by persons with epilepsy cause considerable psychological trauma. Interruptions of consciousness by the seizures themselves and a degree of brain

damage in some cases also lead to psychiatric difficulties. This is particularly true in patients with psychomotor seizures who, in addition to loss of awareness, frequently experience perceptual distortions as an integral part of their epilepsy. A large proportion of patients who experience psychomotor seizures have significant personality disorders of various types.

Does the epileptic have special social characteristics?

The social behavior of individuals with epilepsy is in greatest part dependent on the degree of social acceptance received. Repeated rejection of patients who have uncontrolled seizures sometimes leads them to retreat from social participation and contact. The potential of epileptics in society is similar to that of others and is evidenced by persons with epilepsy who have become great political and religious leaders, artists, musicians, scientists, and athletes.

How early can the symptoms of epilepsy be recognized?

Epilepsy can begin at any age, and the attacks at the onset are as typical as those occurring later. The dramatic nature of grand mal seizures usually calls for prompt medical consultation and early diagnosis. Petit mal attacks often go unrecognized for many months because the child is thought to be daydreaming or inattentive. Bizarre psychomotor attacks are not infrequently mistaken for functional psychiatric disorders, sometimes for many years. Most patients at one time or another will show clearly recognizable epileptic attacks, such as grand mal or focal seizures, as well as the less easily recognized forms. The question of epilepsy should be raised when recurring involuntary movements or changes in state of awareness or behavior occur.

What effect does an epileptic child have on his family?

Families of patients diagnosed as having epilepsy initially harbor the same fears and prejudices that are present in the community. Most families, however, after obtaining accurate information about the disorder, accept their epileptic member as an individual in need of personal support as well as medical help. They make necessary adjustments without seriously disrupting the family unit.

Unfortunately, in some instances, entire family relationships are rearranged so that each member is mobilized toward the constant protection of the patient. This leads to serious disruption of the family's

usual functions and goals as well as to overprotection of the patient. Some parents who feel that their social standing is threatened go to great lengths to conceal the nature of the illness and may reject the affected child. Problems, which are exceedingly difficult when the seizures are severe and uncontrolled, are compounded when there is an associated personality disorder or mental retardation. In such instances all possible resources must be used and institutional care considered.

Are there laws that pertain to the epileptic?

Many laws relating to epileptics are outmoded and in need of repeal or change. Laws calling for the sterilization of epileptics confined to institutions exist in fourteen states. Ten states have laws that deny the epileptic the right to marry. These laws serve no useful purpose inasmuch as the occurrence of epileptic births to epileptic parents is only slightly higher than the occurrence of such births to nonepileptic parents.

Driving a car in the United States is both a social and business necessity. Seven states require doctors to report all cases of epilepsy in order to prevent epileptics from driving. It is unlikely that such rules are helpful. They tend to keep patients from obtaining medical care in order to avoid being reported. A number of states now grant temporary driving licenses to patients with epilepsy. They require that the seizures be controlled and that patients remain under medical care. Since 1949, Wisconsin has had what is considered a model driving law; a license may be issued after two years of freedom from seizures or upon the recommendation of a medical review board. Analysis of the results in Wisconsin has shown that licenses may safely be granted to controlled epileptics.

The legislation committee of the American Epilepsy Society has been responsible for removing many discriminatory and useless laws. R. L. Barrow and H. D. Fabing in their excellent book, *Epilepsy and the Law*, summarize the legal status of the epileptic and offer proposals for legal reform.

What is the effect on the patient when he learns he has a convulsive disorder?

The response of a person who is told he has epilepsy depends in greatest part upon the reaction of others. The attitudes of the physician, family, school, employer, and friends determine his own feeling toward his disability. Unfortunately, lay reactions are frequently based

on fear and misinformation, and some physicians do not appreciate the importance of giving the patient a detailed but reassuring description of the nature and control of the disorder and an indication of the special problems he will encounter. Feelings of unworthiness and fear are common in adolescents and young adults who harbor misconceptions about their illness and its control. Regardless of his understanding, however, the patient inevitably experiences ostracism and rebuffs at school or at work. In spite of the fact that the chances of achieving control of seizures are good, bitterness and hopelessness are frequently encountered.

What are the treatments for epilepsy?

Any disorder that may be the underlying cause of the epilepsy must first be fully investigated and treated. Epilepsy itself is treated primarily with anticonvulsant medication. Diphenylhydantoin (Dilantin), phenobarbital, and trimethadione (Tridione) are three of the most widely used compounds. More than twenty anticonvulsant compounds are now used effectively in the control of epilepsy. Most patients require a combination of anticonvulsants in order to obtain optimal control. It is necessary to continue treatment with anticonvulsants for several years after seizures are controlled. On a limited number of patients with seizures regularly originating from one area of the brain, surgical excision of an affected area is performed.

Although in all cases treatment with medicine is essential, it is in itself insufficient. It is important for patients to receive help in achieving their education and employment goals, and to be encouraged and aided in obtaining satisfactory social adjustment. Such help is considered an integral part of treatment.

What effects do these treatments have on the patient?

About 80 per cent of patients treated with anticonvulsants can be fully controlled or have their seizures reduced to a frequency and severity that is not disabling. Of the limited number needing treatment by operation about 50 per cent are similarly benefited.

Patients whose seizures are fully controlled for more than two years usually can handle the social and employment problems related to their epilepsy. Physically they are able to perform as well as other individuals, and they usually feel psychologically assured that their attacks are completely controlled. They are willing to make social advances and

resume normal relationships. Members of this group will usually conceal their history of epilepsy.

Patients who still have infrequent seizures but who are physically able to work or study suffer the greatest economic and psychological trauma from employment difficulties and social rejection. These patients frequently obtain employment or develop social contacts only to lose them following the appearance of one or a few seizures. It is for this group especially that public education and the breaking down of employment and social barriers are so badly needed.

Patients who, despite treatment, have poorly controlled grand mal seizures are usually unable to find employment. Frequent petit mal attacks are compatible with education and work, and quite a few patients with frequent but mild psychomotor attacks are able to maintain employment.

Can epilepsy be cured?

In the majority of cases, with proper treatment, epileptic attacks are either completely controlled or seizures occur so infrequently that the attacks themselves do not interfere with the individual's ability in social adjustment or his educational and employment goals. The answer to this question depends on the meaning of the word *cure*. If cure means restoration of health by medication, cures are frequent. If cure implies the removal of the cause of an illness, then in the strict sense of the word most patients with controlled epilepsy are not cured, despite the continued absence of all manifestations of epilepsy. Some seizures that are the result of correctable defects, such as those associated with decreased calcium and sugar in the blood, are curable in every sense. This is also the case when surgical treatment cures epilepsy by removing a scar or a tumor.

What agencies or institutions are specifically concerned with the problems and training of the epileptic and his family?

The American Epilepsy Federation, 77 Reservoir Road, Quincy 70, Massachusetts; the United Epilepsy Association, 111 West 57 Street, New York 19, New York; the National Epilepsy League, Inc., 208 North Wells Street, Chicago 6, Illinois; and the Federal Association for Epilepsy, Inc., 1729 F Street, Washington 6, D.C., are national organizations of laymen. They supply information to increase general public understanding, and refer patients, their families, physicians, and professional workers to specific agencies and institutions in the commu-

nity, such as clinics, rehabilitation services, schools, and camps. The national organizations also have programs for the support of research in the field of epilepsy. These organizations appear to be approaching a consolidation into a single group. Should consolidation take place, epilepsy as a national problem will receive greater attention, and funds for research, rehabilitation, and treatment will increase. There are a number of local organizations, such as the Epilepsy Information Center, Inc., 73 Tremont Street, Boston, Massachusetts, which are specifically devoted to the eradiction of public prejudice and to supplying information to patients, their families, professional workers, and others. The American Epilepsy Society is a national medical organization composed of physicians who are devoted to the treatment, study, and eradication of epilepsy.

Over the years medical management has become, to an increasing extent, a community responsibility. The departments of health in a number of states, for example, New York, Maryland, New Jersey, and Georgia, have comprehensive consultative programs supplying diagnostic services and management of drug therapy as a part of their programs of medical rehabilitation. The appearance of state-supported clinics specifically devoted to the epileptic, such as those in New York, are especially valuable because they offer a holistic approach to the solution of the problems of the epileptic. They supply and coordinate the services of the neurologist, social worker, psychologist, and psychiatrist. Attempts to meet the needs for orientation of parents in handling children with epilepsy are carried out by organizations such as the Seizure Clinic Parents' Association at Columbia-Presbyterian Medical Center in New York City, or by having regular meetings of groups of parents with the clinic staff as is done at the Jerry Price Seizure Clinic in the Children's Hospital in Los Angeles.

The epileptic has great needs in the field of rehabilitation through education and training for employment. He is the most difficult of the handicapped for vocational workers to place. The office of Vocational Rehabilitation in New York City was able to place only 12 per cent of epileptics who were eligible for their services. Professional workers who help the epileptic need special training in this field and there is insufficient personnel in this work. The program of the Maryland epilepsy referral clinic includes training of doctors, nurses, and social workers.

There are a few sheltered workshops that employ epileptics. Epi-Hab

L.A., Inc., 8962 Ellis Avenue, Los Angeles 34, California, employs and offers work training for epileptics.

All the services discussed here are supported by public or private funds and are supplied free or at low cost.

Can epilepsy be prevented? How?

Epilepsy is the result of overactivity of brain cells that are irritated by a variety of causes. As each of the causes of epilepsy becomes recognized and can be eliminated or reduced, a portion of epilepsy will be prevented. Epilepsy caused by irritation to the brain from bacterial meningitis has been reduced since the introduction of antibiotic agents. Improved obstetrical methods, which decrease birth injuries, help to prevent epilepsy. Immunization against, and prompt treatment of, infections also prevent epilepsy.

What can be predicted about the rate of epilepsy in the near future?

No marked change in rate is expected in the immediate future. However, a slow but definite decrease in rate can be expected. This will occur in great part as a result of advances in the treatment of metabolic disorders, control of viral infections, and prevention of damage to the brain before and at the time of birth.

What can be predicted about the status of epilepsy in the near future?

One major change in the next few years will be a rapid increase in public understanding of the nature of the disorder and thus an increased acceptance of the epileptic person into industry, education, and the community in general. The desired increase in public education concerning epilepsy will come as the result of the aggressive programs of the organizations concerned with dissemination of information and the consolidation of the present national groups into a single effective society.

Additional anticonvulsants will become available in the next few years and they will add significantly to the effective control of epilepsy.

What are the other types of paroxysmal disorders?

In addition to epilepsy in all its forms, paroxysmal disorders include nonepileptic conditions, such as narcolepsy, cataplexy, and migraine.

What are narcolepsy and cataplexy?

Narcolepsy is characterized by recurrent uncontrollable periods of sleep, which usually occur several times daily. These involuntary bouts of sleep are usually preceded by a drowsiness that occurs in spite of intense occupation with work and strong conscious attempts at keeping alert. Cataplexy is characterized by the abrupt appearance of episodes of muscular weakness with loss of the ability to move. The attacks last only a few seconds and are practically always precipitated by exaggerated emotion, e.g., laughter or excitement. Cataplexy and narcolepsy usually coexist in the same individual.

What is migraine?

Migraine is characterized by paroxysms of severe recurrent headaches usually involving one side of the head. The attacks are practically always associated with loss of appetite or nausea, and vomiting is also common. Visual disturbances such as the appearance of shiny or colored forms of light sometimes precede the headaches. Many individuals with migraine have a distinctive personality constellation. They tend to be intelligent, conscientious, hardworking, perfectionistic, ambitious, orderly to the point of rigidity, and extremely neat in their work and dress. Most people with migraine have relatives with similar attacks.

Abnormalities in the electroencephalogram that are considered characteristic of epilepsy are not found in individuals with narcolepsy, cataplexy, and migraine, and these individuals do not respond favorably to compounds that are helpful in epilepsy.

EXISTENTIAL THERAPY

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What is existentialism?

Existentialism is a broadly based cultural movement that arose in reaction to the growing sense of alienation, rootlessness, and fragmentation that pervades the life of contemporary man. It is not a systematized body of thought or knowledge, but rather, a way of thinking, one that attempts to come to grips with the paradoxes of modern life, and to understand the conditions of human existence that underlie man's apparently insoluble dilemmas. In exploring the structure of reality, existentialism focuses on "being," in contrast to other philosophies that center on religious, political, scientific, or metaphysical questions.

Although man is capable of miraculous achievements, he often experiences himself as a homeless stranger in the natural world. He questions the meaning and purpose of his life. Because of the extension of his power over nature and over his fellowman, he feels himself as being set against nature, set against other men, and even set against himself. Existential thinkers point to the whole development of Western thought as being responsible for man's feeling of bewilderment. Western philosophy, according to the existential thinker, has bred and fostered these schisms by extracting man's rationality from the context of his total functioning and blessing it with divine characteristics, at the same time damning the intuitive, emotional, and irrational aspects of his being as sinister, animalistic, and worthy only of the devil. Existentialists in literature and art mirror this image of the fragmented man. Existentialists in religion, philosophy, and psychology attempt to understand the schisms that have grown into man's being, and to make him respectable again in his wholeness. *(See Religion and Psychiatry)*

What is meant by "man's existential predicament"?

Man is unique in the animal kingdom in that he possesses the capacity for consciousness; specifically. for consciousness of himself. He acts, reacts, thinks, feels, and senses, and at the same time is able to see himself as the one who is doing the behaving. He is not bound to the

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existing moment, but is able to see around it, to relate it to the past, and to project it to the future. He can come to know his potentialities and choices which govern his behavior and the unfolding of these potentialities. However, this freedom is restricted: man is part of the natural world; he is subject to the laws of physics, chemistry, and biology; he is limited by his unique constitutional endowment, by his particular past and present, by his social and cultural environment. His is a limited freedom, or a "finite freedom" as the existentialists say.

Another way of stating the "existential predicament" is to say that human nature does not unfold according to a fixed, inborn, instinctual pattern, nor is human destiny imposed by some transcendental authority, but rather, that man is continually confronted with the necessity of making choices that will determine his existence and fate. Confronted, on the one hand, with freedom, choice, and responsibility, and on the other, with limitation, restriction, and uncertainty, man experiences the dilemma and anxiety of his predicament. (See *Ego; Culture and Personality*)

Is this a doctrine of negativism and despair?

Essentially no. Jean-Paul Sartre, who happens to be most often identified with existentialism in the United States, emphasizes nihilistic aspects in his writings, but he is by no means totally representative. It is true that anxiety, meaninglessness, crisis, despair, and irrationality play a large part in all existential thinking, but so do they in our everyday contemporary life. And it is not existentialism that put them there. The existentialist points out that man is not wholly a creature of pure and enlightened reason as our rationalistic tradition would have it, and he has the evidence of modern society's individual and collective "madness" to prove his point. Irrationalities are a fundamental quality of being human, and to deny them or alienate them is to flee from the self and from its sources of vitality and creative potential.

Just as the wartime pilots who could admit their fears performed better and had fewer breakdowns, so the acknowledgment that man's existential predicament leaves him continually troubled and anxious, frees him to confront this anxiety and to deal constructively with the choices available to him. The recognition of the transitory nature of human existence (and maybe even of the species, as evolutionist George Gaylord Simpson has pointed out) frees man from the quest for certainty that so often impedes his search for meaning in life.

What is the philosophic background of existentialism? Who are the people responsible for its development?

Although existential elements appear in the works of philosophers as far back as the ancient Greeks, the movement really began with the works of Sören Kierkegaard (1813–1855) and Friedrich Nietzsche (1844–1900). The central subject of their writings is the experience of the individual being in crisis—the human personality itself in its struggle for self-realization. They do not deal in abstract ideas or conceptual systems so characteristic of the academic philosophers of their time.

The other main contribution came from the work of Edmund Husserl (1859–1938) who, though not an existentialist himself, gave existentialism its method of investigation. His method was simply to observe, without any theoretical or preconceived bias, the phenomena of being, as they manifest themselves. His aim was to let the actual concrete data of experience provide the foundation for a new psychology and philosophy.

Husserl's pupil, Martin Heidegger, is generally considered to be the founder of contemporary existentialism. His writings are extremely difficult and complex, but are in essence an analysis of "being" that differs markedly from the ways in which human existence has been considered in the past. Heidegger's work has influenced most other existential philosophers, among whom are Karl Jaspers, Gabriel Marcel, Nikolai Berdyaev, Martin Buber, Jean-Paul Sartre, José Ortega y Gasset, and Paul Tillich.

Why was this philosophical idea incorporated into a psychological discipline? What people were instrumental in evolving this discipline?

One can see from a description of the philosophy of existentialism that it has an inherently psychological orientation. In fact, it might be more useful to ask the question this way: Why were these psychological insights incorporated into a philosophic system? The important point, however, is that psychologists, philosophers, and even theologians, had begun to raise questions about their own traditional approaches to their respective disciplines. Certain thinkers in all these fields began to realize that in their concern for elaborating logically coherent theories and all-inclusive rational systems by means of apparently sound scientific methods, they had left out the unique, live, experiencing individual.

In academic and experimental psychology, the traditional approach had been to study different human "faculties," for example, the work-

ings of the sensory organs or the operation of perceptual processes. Even in the field of psychotherapy, such things as egos, ids, energy systems, and dynamisms, seemed to occupy the center of the stage. No one discounts the importance of all these areas of study, but the existentialists say that their real significance comes to light only in the context of a person's existence.

The phenomenological method, in focusing on human experience, offered a way of making the reality of the whole person the core of the study of human behavior. It was this method that provided the bridge between existential philosophy and psychology. Although the phenomenological approach has been used in many areas of psychological investigation, the clinical research of Karl Jaspers, Erwin Straus, Eugene Minkowski, and Viktor E. von Gebsattel is most closely related to psychotherapy.

What is Dasein?

It is a German word that means "being" (*sein*) "there" (*da*). It is Heidegger's term for man, and with all its connotations it is the central concept in existential philosophy. Heidegger's thesis is that man's existence does not take place within himself as separate from his world. It is impossible to think of man (the subject) as apart from the world (as object). Modern philosophy has been plagued with conceptual problems stemming from this subject-object split; the mind-body problem is an example of the outgrowth of this dualism.

Man is of the world right from the start. He is a field or region of being. His being inheres in all that is his world. His world consists of all that he is concerned about, cares for, or is affected by. Man is not only in a world and has a world, but also shapes or makes his world. By his choices and decisions he continually structures and delimits the particular "there" of his being. Hence, *Dasein* is not a static concept, but one that connotes an ever-changing field of becoming. Man's existence is a dynamic process of endless potentiality becoming actualized, of his potential world becoming his actual world.

Since man participates in the unfolding of his world of being, he bears responsibility for it. He is aware of himself, conscious of himself as choosing his particular existence. But the choosing is never finished, so man is oriented toward the future. *Dasein* is a temporal concept in which the future is dominant. However, it is not an abstract future, but one that is very much alive and active in the present moment.

It is impossible here to give more than a suggestion of the richness of Heidegger's concept of *Dasein*. Furthermore, it is difficult for one not familiar with his work to empathize with his concepts because they break so sharply with our traditional ways of thinking about human beings.

What is existential psychology? What are its purposes? What is its method?

Existential psychology is the body of psychological theory, practice, and research that reflects an existential influence. It is not a separate and distinct psychological system.

The purpose of much of the work that reveals this influence is to explore and understand the different aspects of human reality from the viewpoint of the experiencing individual.

Although the phenomenological method is fundamental to the existential approach, other psychological methods of investigation and · understanding are not ruled out. However, technique and method are not ends in themselves, but are always subordinate to the ontological understanding of man. Ontology is a term frequently used in existential writing; it means the study of "being."

Why have psychotherapists become interested in existentialism? Who are the leaders in the development of existential therapy?

It is rather startling that psychotherapists, representing every psychoanalytic theory, have at least some patients who improve as a direct result of therapy. However, psychotherapeutic practice is not really so varied as the profusion of theory suggests. Rather, the better qualified and more experienced therapists of different theoretical schools are more alike in their work than are proficient and poor therapists from the same school. How relevant, then, is current theory to actual practice? And to what extent does current theory stimulate our thinking about psychotherapeutic work and generate new knowledge? Perhaps, much good therapy is being done despite theoretical considerations rather than because of them. More and more, therapists themselves question even some of those therapeutic procedures that have been accepted by most schools.

A second major question concerns the goals of psychotherapy. The implied goal of much therapy is a reduction of tension. Indeed, the expressed goal is often the state of reduced personal and social tension known as adjustment. But adjustment fosters conformity. How then

do we theoretically justify and practically implement the goals of individuality, creativity, and self-fulfillment which have become more highly valued by most therapists?

Precisely these issues—the discrepancy between theory and practice, the inadequacy of many therapeutic procedures, and the limitations of conventional goals—have led to the developing interest in the existential viewpoint. There is an obvious need to broaden our understanding of man and to provide the theoretical framework upon which effective therapy can be consistently based. Many therapists, such as Ludwig Binswanger and Medard Boss in Europe, and Rollo May in the United States, believe that existentialism can provide this framework. (See *Psychotherapy*)

Are there various existential therapies?

There is really no one existential therapy. Just as in philosophy and psychology, there is no elaborated, systematic position in psychotherapy. What is referred to as existential therapy is the attempt to put all psychotherapies on a sounder basis by integrating the findings of the phenomenological approach and the insights of the existential inquiry into the nature of "being," with those techniques and concepts of other therapeutic positions that are useful and valid.

What are the qualifications for an existential therapist? How can an individual find one?

Since there is not a separate and distinct discipline of existential therapy, it follows that existential therapists are not a clear and distinct group. They are essentially psychotherapists and psychoanalysts affiliated with various existing "schools" who are interested in existentialism and the contribution it can make to their thinking and their therapeutic work. Consequently there are no formal qualifications other than those relevant to professional competence in the practice of psychotherapy.

Although there are a number of professional organizations of existentially oriented therapists, they are exclusively interest groups and not qualifying or certifying organizations. In general, the best advice to a person seeking a therapist is not to be concerned primarily with the theoretical orientation of the therapist but rather with his professional training and competence. Since there are many theoretical divergences it is reassuring to know that there is some formal and much

informal evidence to indicate that competence is a better predictor of a therapist's functioning than his professed theoretical orientation.

How does existential therapy differ from other psychotherapies?

If a list were made of what existential therapists do, it would be very much the same as a list of what other therapists do. The differences lie not in techniques but in the context in which these techniques are employed. For the existential therapist, the central process of therapy is the experiencing of one's existence, and its goal is the fuller awareness of one's being. Techniques are used flexibly and for reasons dictated by the therapist's attempt to understand the nature of the patient's "being-in-the-world." The following contrasts will perhaps clarify the context of existential therapy.

The existential therapist emphasizes experiential awareness as opposed to cognitive awareness. He is concerned with the patient's understanding of what is happening, rather than why it is happening. He feels that the patient's full recognition of his present experience will include in it his meaningful past experience and the connections between the two. Understanding why one behaves in a particular way is an empty intellectual exercise unless it grows out of experiencing that particular way.

Related to this is the existential therapist's emphasis on the here and now in contrast to a historical perspective of the patient's life. The patient's symptoms, repressions, dynamisms, etc., are understood and explored primarily as ways of "being-in-the-world." Although they have developed out of the past experiences of the patient, they nevertheless have their significance in the present, in the ways in which they limit, determine, and structure the unfolding of the patient's potentialities. In fact, the very recollection of the past is determined by the nature of one's commitment to the present.

A third contrast concerns the nature of one's identity. For the existential therapist identity is not a fixed quantity that is given at some time and then covered over. A person does not "find" himself but continually "creates" himself. Therapy, then, is not primarily an uncovering process, but a creative one. It is the self-making aspects of being that are in the foreground—one's decisions, commitments, and responsibility. The existential therapist is not content with the elimination of undesirable aspects of functioning such as inhibitions, frustrations, and symptoms, but has the larger goal of the creation of positive values.

Finally, the nature of the relationship between therapist and patient may be very different in existential therapy from the relationship in the more classical kinds of therapy. The original concept of the role of the therapist was that of a *tabula rasa* (blank slate). The therapist's task was to reveal nothing of himself, but to allow the patient to project his own feelings, expectations, perceptions, etc., onto the person of the therapist and thereby see his projections mirrored in the therapist. The patient's projections then become the object of the analytic process— to be understood in their relation to the patient's past experience. The existential therapist does not function as a mirror reflecting back the patient to himself, but functions as a person in a meaningful encounter with another person. This specific relationship is spelled out in the following section.

It is important to restate that the differences elaborated here are not black and white differences, but matters of emphasis. The contribution of existential therapy is that it provides a theoretical foundation which incorporates and makes explicit what has always been intuitive in effective and useful psychotherapy.

What is the relationship between therapist and patient in existential therapy?

Paul Tillich has written, "A person becomes a person in the encounter with other persons, and in no other way. This interdependence of man and man in the process of becoming human is a judgment against a psychotherapeutic method in which the patient is a mere object for the analyst as a subject."

The concept of encounter does not refer simply to an interpersonal relationship. It refers rather to the unique form of relatedness in which each (of two people) participates with his full being in the world of the other, without treating the other as an object subordinated to some purpose of one's own. An encounter implies a profound respect for the worth of the other person, and an interest and concern for him that results in one's being fully present and completely real with him.

This provides the setting for the uniqueness of the therapeutic relationship about to unfold. First, the therapist participates in the patient's world as it is constructed within the confines of the analytic office. He is not merely a tolerant observer and intellectual analyzer, but a human being sharing in the experience of another being. Second, the therapist has an unconditional acceptance of, and regard for, the patient. That is, the patient's worth as a human being is not a function of his de-

sirability, pleasantness, adequacy, or capacity to fulfill the needs of the therapist. This does not mean that the therapist must be uncritically accepting of all of the patient's behavior. On the contrary, the therapist may be quite critical, but his criticism must be directed at the self-imposed limitations on being, never at being itself. Third, and perhaps most important of all, the therapist is fully present to the patient, and it is by virtue of this—the therapist's full presence—that the patient is unable to reconstruct his neurotic world.

To be fully present means to be subjectively real, consistent in the feeling and expression of one's emotions, focused on the here and now, and open to the possibilities of current experience. Such a state of presence makes it impossible for the therapist to be treated as an object, and the patient must contend with this fact. It is as if the therapist were saying, "I'm here with you in this world of you and me. I'm here as a real person, not as an object or thing."

Although this is descriptive of the therapeutic relationship in its essence, all human relationships are subject to existential limitations. No therapist is completely free from neurotic restrictions of his own. Therefore, the therapist's participation, unconditional acceptance, and presence in the therapeutic relationship are always more or less operative. However, the existential therapist is oriented to "analyzing out" the blocks to his own presence in the relationship. This description is not meant to imply that this kind of relationship is exclusive to existential therapy, but rather that the stated existential relationship actually occurs in all good therapeutic relationships, whatever the theoretical background of the therapist.

> *How might an existentialist's attitudes and actions regarding everyday living differ from those of his contemporaries?*

Two major areas in which the existentialist's attitudes and actions might differ are those having to do with anxiety and with the meaning of life. Since the existentialist sees anxiety as a basic condition of existence, he would expect to experience it, particularly in connection with his choices and decisions. In fact, the absence of anxiety in the presence of meaningful moments of everyday life might make one wonder how committed a person is to the course of action at hand. This kind of attitude toward anxiety can be illustrated in the relationship between parents and children.

So often in our society we hear parents say that they would take an

unpopular, unconforming stand, for example, with regard to religious affiliation or political position, but they have a responsibility to protect their children and, therefore, they can't take the stand they believe in. In effect, what they will be communicating to their children in the long run is that being oneself is a bad thing, because it exposes one to anxiety, and anxiety is something bad. But it is impossible to be oneself and not experience anxiety. This kind of existential anxiety is not destructive to people; only the fear of it that leads to denying one's being is destructive. The child will be better equipped to develop his own unique potentialities if he has the example of his parents doing so. He will be better able to deal creatively with his own "existential predicaments" if his parents do not "protect" him from the concomitant anxiety, but rather help him to confront it and move through it. (See *Anxiety*)

Related to this is the existential conception that life's meaningfulness lies in the "courage to be," as Paul Tillich's book is entitled. In our contemporary age the problem of meaninglessness is pervasive. People continually question the purpose of life and seek out allegiances or achievements that will give their lives meaning and purpose. They become "joiners" or "collectors." They make themselves acceptable, adaptable, and marketable. But so often they find themselves experiencing the same feelings of emptiness and purposelessness. They make the mistake of looking for a purpose, a certainty, an identity outside of themselves.

The purpose or meaning of life is not something handed down or ordained by any kind of external authority. Rather it is to be created by each of us for ourselves. What makes life meaningful for each of us is the process of becoming what we are capable of being, the process of developing our uniquely human capacities for love, responsibility, and creativity. This is not to say that allegiances and achievements are irrelevant, but rather that one's orientation to them may be radically misdirected. Belonging to a religious denomination, for example, does not give life meaning, but the way in which one lives out religious values does. Having many friends or having children does not create meaning, but the nature of one's participation in these relationships does. Being a talented person or having a good job does nothing to guarantee a purposeful life. It is in the exercise of one's talents and the commitment to the responsibilities of one's job that satisfaction and purpose are to be found. (See *Morals, Values, and Mental Health*)

What are some examples of existential therapy in action?

Since existential therapy is not distinguished by any particular therapeutic techniques, but rather by the therapist's orientation toward human beings and their relationships, a description of a case would not be especially illuminating. However, a contrast between an existential and nonexistential way of dealing with some particular situation arising in therapy might be useful.

During his first therapeutic session, a handsome and virile young actor began haltingly to describe, with great anxiety and embarrassment, the problem that brought him to seek therapeutic help. Although he was sexually potent in his relationships with women, he could not rid himself of doubts about his adequacy. The most disturbing fact of all was that he found himself compulsively driven, on occasion, to expose himself surreptitiously to little girls. The nonexistential therapist might, with this information, question further the patient's relationships with women, his sexual history, or the conditions under which exposing himself occurred. The existential therapist in this case replied, "It really is painfully difficult for you to tell me about this, isn't it?" The therapist focused the session on the patient's immediate experience in revealing his symptoms rather than on the symptoms themselves, with the result that the patient felt understood and consequently trusting. Of course, the therapist would want to know more about the patient's sexual symptoms, but at this moment the patient's concern was with his feelings vis-à-vis the therapist.

Medard Boss, in *Existence,* edited by Rollo May *et al.,* cites the case of a man who had had a recurrent dream involving church steeples. Then followed a period in which he dreamed repeatedly of a locked lavatory door. Instead of interpreting these dreams in terms of Freudian phallic and anal symbols or Jungian religious archetype symbols, Boss kept asking why the door needed to be locked. In this way he kept confronting the patient with his own responsibility in cutting himself off from his essential potentialities, in locking himself out from aspects of himself. Finally, the patient dreamed he went through the door into a church where he was standing in feces and was tugged by a rope from the steeple. Boss points out how the patient had denied both the bodily and spiritual possibilities of his existence, but it was not until he could in some sense recognize and acknowledge his own complicity in avoiding these experiences that he could begin to change.

A six-year-old girl, who was very disruptive and especially messy in

her behavior, came to one of her sessions and said she had to go to the bathroom. She asked her therapist to go with her. While sitting on the toilet, she said, "I could really mess this place up." The therapist said, "Yes, you probably could if you wanted to." She then described what she could do to mess it up—throwing water around and smearing things up. Again the therapist repeated that if she wanted to mess it up she really was capable of doing it. She smiled at this and left the bathroom saying, "I'm not that kind of girl."

This illustrates the way in which the existential therapist attempts to make the patient aware of his choices in life. This girl had been using her messiness compulsively as the way of asserting herself against oppressively restrictive parents. In coming to realize that it was a way *she* chose, and that there were other ways of being she could also choose, she was able to make positive choices in her own self-interest and not limit herself to choosing against someone else.

It is not the intention in these examples to leave the reader with the impression that only avowed existential therapists would handle these situations in the ways described. Probably many competent therapists would do likewise. Existential therapy is not a different kind of therapy, but an approach to understanding human nature and the therapeutic process that, we hope, enables the therapist to function more effectively and more consistently.

Is there any strong opposition to existential therapy?

Yes. The opposition is not confined to any one group but exists in individuals throughout the profession. Rollo May enumerates three sources of this resistance. First is the resistance that any new contribution meets from those with a rigid proclivity for maintaining intact that which exists. Second, there is the feeling that existential therapy represents an invasion of nonscientific philosophy into psychological science. The third source lies in our cultural predilection for practicality. We are preoccupied with workable techniques and impatient with the search for the substance upon which the techniques are based.

Is the acceptance of existential therapy on the rise?

The situation differs in Europe and in America. In Europe the existential approach has been more readily accepted and integrated into existing schools of therapy. In the United States there is an almost reflexive opposition and at the same time a great deal of interest within

the profession. It is hard to estimate what correspondence exists between the interest shown in hearing about existential therapy at meetings, and actual acceptance of the existential approach. Some influential therapists like Carl Rogers, for example, who is not an existentialist, have increasingly come to express their own thinking and research findings in terms very similar to those of the existentialists.

What is the potential of existential psychology as a medium of research?

Existential phenomenology has already demonstrated its research potential in a wealth of studies ranging through the whole gamut of human and animal behavior. Adrian Van Kaam has published an extensive review of this literature in the *Review of Existential Psychology and Psychiatry* (Vol. 1, No. 1, 1961). However, the more ontological concepts having to do with identity, with self, with psychological freedom, and the parameters of existential therapy have not as yet received any extensive research formulation. Our research methods have not generally dealt with the uniqueness of the individual, nor with unique aspects of his experience. But there is a beginning effort in this direction in the work of Carl Rogers and his students on the psychotherapeutic process, and in the work of Abraham Maslow on peak experiences of human beings. Certainly an important measure of the value of the existential approach lies in its capacity to generate researchable hypotheses, as well as in its therapeutic effectiveness.

THE FAMILY IN ILLNESS
AND HEALTH

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Does mental illness "run in the family"?

Yes. Mental illness (and mental health) are not randomly distributed in the total population. Various studies of the populations of particular cities indicate that a small portion of families account for a large percentage of mental disorders. These families also show higher than average rates of physical illness, crime, and use of welfare facilities. However, it is unclear whether this "piling up" of psychological and social problems reflects an actual difference in rates of occurrence or merely a difference in how readily identifiable as problems is the behavior of different segments of the population. While no definitive studies exist as yet, available evidence points toward the conclusion that mental illness does occur in some families more frequently than in others.

Does this mean that mental illness is inherited through "bad genes"?

Since the appearance of mental illness in two or more members of the same family increases in proportion to the closeness of blood relationship, many geneticists and some others have concluded that mental illness is genetically inherited. Others contend that blood relationship has a psychological importance and that not even identical twins reared in separate households (an abnormal situation in itself) have truly independent environments. They thus discount the genetic explanation and favor environmental explanations. Posed in an "either-or" fashion the question is unanswerable. There is growing evidence that biologically inherited potentials may be reacted to in various ways and result in quite different outcomes. For example, children born with a congenital dysfunction of the nervous system frequently, but not necessarily, develop emotional problems when parental expectations are out of line with what is biologically possible. The same qualification

needs to be applied to the generalizations of the radical environmentalists who maintain that problem families produce problem children and problem children grow up to establish problem families. A less biased and more valid position would be that every individual is born with certain biological potentials which become actual only through interactions with the environment. In the case of the human infant with its long period of dependency, the most significant shaping environment is the family.

Do lower animals and insects have families? Does this not suggest that family emotions are instinctive?

Various animals and insects have familylike relationships such as monogamous mates, mother-child dependency, and sibling rivalries. When such relationships are interrupted there are reactions of some magnitude. Some species are even felt to develop emotional disorders. Monkeys, for instance, have very different reactions to the stress of being startled, depending on the nature of their contact with a mothering (comforting) object. Puppies develop different behavioral controls (superegos) depending on whether they have been fed and punished by humans or by a mechanical apparatus. Whether such patterns of behavior should be called a family system is a difficult question, the answer to which depends on how terms are defined. It seems clear that there are many dangers of reading human responses into the behavior of lower animals and insects but that the line between human and other species is less absolute than was long thought.

The familylike qualities of some lower animals raise the question of whether or not familial behavior patterns and emotions are instinctive or not. If instinctive means present from birth in full form, then lower animals are dubious proof. Much of what appears as instinctive behavior depends on early imprinting, and is capable of some modification. In the light of such evidence it is hard to maintain the position that there is any appreciable amount of behavior that is truly and completely instinctive. In the case of the human family it is quite clear that there are no love or hate emotions that can be explained solely on the basis of the individual. Rather there are potentials (or drives) which are channeled by the patterned relationships of the family. To take but one example: incest taboos are no more "natural" than is the expression of love between husband and wife. These taboos are inculcated in members through experiences in their relation to each other, and very little through conscious teaching of the moral principle. The

learning of acceptable patterns of expressing love and aggression is, of course, not always successful. Whether the process of inculcating and maintaining acceptable modes of expressing impulses is successful or not depends on the complex we call the family environment.

How is the family environment associated with mental stability or disturbance?

The human species differs from other species in degree, being more plastic and capable of complex organizations of behavior. A most critical factor is the human ability to acquire and to use language. Human behavior then becomes a complex resultant of biological drives, physical potentials, and what the environment defines as appropriate and acceptable. In other words, through the acquisition of symbols, behavior comes to be directed toward goals and is regulated by the norms of the group as exemplified in the actions and reactions of various role partners. Gradually this interplay of drives and experience in relationships structures the individual's mental organization. Both stability and disturbance of the personality develop and are generated and maintained through these processes.

Of the web of relationships of which a family is made up, most attention has been paid to the mother-child relationship. It is widely assumed that the qualities of this tie have a strong determining influence on personality formation; much disturbance is attributed to the depriving, rejecting, overprotecting, seductive, or a host of other traits of the mother. While the person who carries out maternal functions is of central importance, especially in early life, the picture is never so simple. The behavior of the mother and the relationship between her and the child is patterned by the rest of the family, by the society, and by the values current in that society. For example: the impact of a cold, rejecting mother will vary depending on whether the father accepts this as the right way for mothers to behave and supports her, or whether he views his wife as a poor mother for whom he has to make up. Thus it is to the total family constellation and family interaction patterns that one must look.

To date, relatively little research has been completed on the topic of family forces and personality stability. Some workers have emphasized structural features in the background of schizophrenia such as persistent and pervasive schisms within the family in which the child is allied rigidly with one parent and sharply separated from the other, or the building into the family of markedly disturbed (for that particu-

lar culture) relationships. Others emphasize as pathogenic, processes such as pseudomutuality—the acting as if the relationship is of a quality that it is not really felt to be—or the communication of mutually contradictory messages which cannot be questioned so that the child is in a "double bind." Basically such family patterns make it difficult for a child to progress through the normal stages of identifying itself with persons of both sexes and units of several levels of complexity. When this process is defective, the individual has difficulty in achieving an identity which allows him to be a capable member of his society. More generally it might be formulated that when there are basic conflicts in the family which are never resolved but live on to distort relationships, the likelihood of maladjustment is high. Conversely, when basic conflicts are acknowledged implicitly or explicitly in family interaction, there will not be the same need to distort relationships and induce members to take roles which, when internalized (adopt as one's own the values and standards of another), result in disturbed individuals. These basic conflicts may revolve about differences in the underlying premises about what kinds of behavior and character are preferred, permitted, or proscribed in that culture, about differences in the goals toward which behavior is directed, about cognitive gaps in understanding, about what "equipment" (biological or other) is necessary for carrying out a role, or about the coordinating issues of how people get in and out of various roles.

Are certain types of families more likely to have disturbed patterns?

It has been fashionable at various times to maintain that divorce, desertion or death, working mothers, interfaith or interracial marriages, or the decline of the authority of the father spell the doom of the family and guarantee a future generation of misfits. The evidence does not support such prophecies. Broken homes, for instance, appear to be a quite nonspecific factor, appearing in the background of a wide range of disorders, both somatic and psychic. It is not clear how biased are the samples studied and what relationship they bear to the total population. No simple general statement seems valid. But such changes—indeed any change, from the birth of another child to the loss of a father's employment—alter the tasks which the family has to cope with and the situation within which it must cope, and thus has the potential for altering the equilibrium a family has achieved. The effects will depend more upon how the family adjusts or readjusts to altered conditions than on the conditions themselves.

Are specific positions in the family—the only child, or the youngest child—more likely to produce problems?

Much importance has been attributed to the difficulties faced by an only child, an eldest child, a middle child, a youngest child, the only boy in a family of girls, and so on. Other theories hold that particular times in specific positions in the family are dangerous, such as when an eldest male child reaches the age at which the father's oldest brother died. Once again the evidence that such specific conditions or positions are necessarily problematic is inconclusive. And once again it would seem more likely that a particular position or time is a fact to which the family and each member must adjust.

Still, in regard to position, the effects do not seem to be completely random. Second children born into a different situation and, in a sense, to different parents, do develop somewhat different personality patterns than the firstborn. Some recent work has shown that sex-role learning is in part a function of the sex of the sibling and the ordinal position. For example: a boy with an older sister has more feminine traits than a boy with an older brother or a boy with a younger sibling, male or female. Such differences are subtle and complex, and, one might suppose, difficult to evaluate in particular cases, especially pathological cases. On the other hand, Theodore Lidz and his co-workers, who have studied the families of schizophrenics intensively, find that the evidence of disturbance is higher in same sex siblings than cross-sex siblings of schizophrenic patients. Thus there may be some general dispositions created by position. Our knowledge is as yet insufficient to allow any general propositions that would hold across a wide variety of disorders and in a wide variety of situations.

What are the different types of family systems?

Over the face of the earth there are wide variations in family systems. All societies have some institutionalized patterns that regulate procreative and child rearing relationships. Variations occur in the composition of household units, in the form of marriage relationship (i.e., whether monogamous or polygamous), in the range of persons who can become spouses, in the range of activities which center in or revolve about the family group, in the division of labor within the family, between sexes and generations, how the activities of different members are related, and in the quality of interaction allowed or permitted (e.g., the amount of authority, dominance, submission, and

independence, or the amount and kind of emotional expression al-
lowed).

Our own society stresses the family ideal of monogamous marriage
to a spouse of one's own choosing, independence of the nuclear family
unit of mother, father, and children, the relative equalization of the
sexes, the emphasis on responsible authority, the respect for the in-
dividual, and the existence of many specialized agencies outside the
family for education, economic production, political control, religious
observance, etc. In some societies mates are chosen from a narrow range
of possible partners by one's elders; the residential and operating unit
for many purposes is an extended family. Strong authority is vested
in a father or grandfather, the family rather than the individual is the
important unit, and a very broad range of activities are organized
around the family (usually the extended family) unit. On another
dimension, a sector of Israeli society, the *kibbutzim* (collective settle-
ments), has developed specialized agencies which carry on a good deal
of (but not all) child care and rearing outside the nuclear family unit.
Such diverse types of family system are all capable of meeting the basic
biological and psychological needs of children and at the same time are
"workable" for adults. It is significant that no society has ever suc-
ceeded in abolishing the family as an institution. During the 1920's,
the new Communist government in Russia tried to abolish or at least
very radically alter the family by such measures as making marriage
and divorce matters for individual decisions, abolishing inheritance,
and legalizing divorce. Evidently so many social and personal ten-
sions developed that the policies had to be reversed.

Differing family systems, as might be expected, produce varying
types of personality. The variation is a matter of degree; there is a
common ground of personality development. Israeli children reared
on kibbutzim develop social skills, social maturity, and group identifi-
cation more readily than children raised in traditional nuclear families.
Those kibbutzim children develop less intense oedipal conflicts, less
sibling rivalry, and more group rivalry. By way of contrast an African
tribe, the Dobuans, are reported to inculcate a very high degree of
suspicion and jealousy. But whatever modal personality patterns exist
in a society, it is an oversimplification to attribute them solely to the
family, let alone to a segment of behavior within the family such as
toilet training. In many respects the family is but the mediator of
broader social and cultural forces. Families cannot nurture personal-

ities which do not "fit" with the society and its value orientations, at least not without producing maladjusted persons.

How is American family life changing?

One hears dire predictions about the future based on high divorce and crime rates, the loss of the father's authority, the loss of family functions, the increase in illegitimate births among young girls, the increase in alcoholism, etc. Changes certainly are taking place, but they are by no means clearly in one direction. Basically the American family appears to be becoming a more specialized unit, fulfilling functions of socialization of the young, stabilization of personalities of adults, and the maintenance of social and cultural patterns. In the process, tendencies for individuals to be taken as the most important unit and for equality to be stressed have increased. The authority of parents has become more responsive to the opinions of youth and of society, but has not necessarily been weakened.

Such changes cannot help but leave their mark on our "national character" and on the personalities of younger generations. In the short run a changing family system may increase the prevalence of disorders. In the long run, however, the American family is a piece of a larger picture and is well adapted to producing individuals well equipped for a technologically complex, urban, industrial society.

Do some types of family interaction lead to mental abnormalities?

From the discussions above it will be clear that we need to exercise a good deal of caution in our evaluation of what is "normal" and what is "abnormal" in family life. There are a few things which are biologically inappropriate, e.g., treating a male child as if he were female, or tabooed activities such as incest, or homicide, contravention of which is likely to be traumatic. Beyond such factors, the human being is amazingly but not infinitely plastic. Any evaluation of patterns of interaction needs to take into account the total context in which it occurs, within and outside the family. A harsh, authoritarian father may cripple children emotionally in one society, but in another this may be the best training for people who will grow up into adult roles which emphasize respect, obedience, bravery, and the suppression of emotion.

This point is of some importance since it has been maintained that

the mental health movement embodies the values of the American middle class, values which may not be shared by other groups. Pressure on someone to "stand on his own feet" and "make something of himself" and "get ahead in life" may be appropriate for some people, but for some lower-class immigrant families would be a potentially disturbing force, which would encourage individuals to "get out of line" or be "disloyal" to the family. Even our emphasis on the sacredness of the family and the positive value attached to "family togetherness" should not be carried over to other groups. For lower-class Negro families in the South and some Caribbean countries, family stability and a "stable father figure" cannot be expected since men have little chance of being economically stable or politically (in the broadest sense) vocal. In such circumstances quite different, but viable, family systems develop.

Can normal children be reared outside of families?

Obviously physical life can be sustained in other than family settings. Emotional development is more problematic. Human infants require a prolonged period of dependency with an intensity and continuity ot relationships not easily provided in large organizations. Even prolonged separation from parents by hospitalization of a young child has been noted frequently to produce depressive reactions of considerable intensity. Curiously, there seem to be few good follow-up studies of children reared in institutional settings. It is even difficult to determine how many children, other than defective ones, spend their early years completely outside a family setting.

Isolated cases demonstrate that it is possible for children to grow up in institutions without major stunting. Such individuals would appear to have been able to establish a nurturant relationship with a parent substitute. Cases of children reared in isolation or by animals show gross disturbances of emotional development, disturbances which cannot be reversed after a certain point. It is significant that no society, or even a substantial group within a society, has achieved an enduring pattern of rearing children outside any type of family setting. It will be recalled that the collective settlements of Israel do not totally replace the parent-child relationship with nursery and school life. Even the kibbutzim arrangements are undergoing changes (toward more traditional family life) for a complex of ideological and political, as well as familial, reasons.

Do social conditions affect family mental health?

Families do not exist in a vacuum any more than individuals or mother-child relationships do. The social conditions under which the family lives may have a strong influence upon its life and the health of individuals. Any crisis that disturbs established ways of life or makes established ways ineffective or inappropriate will set a chain of reactions in motion. Depending on the reactions to changes, the end result may be the disruption of the family and/or certain individuals, or even increased stability. During the depression of the 1930's many men were faced with the loss of gainful employment. In some families the father was seen as a failure; he lost esteem in his own eyes, became more disorganized, and went through a spiral of losing authority while still trying to assert it. This disorganization increased until a breakdown of an individual, or a breakup of the family, occurred. Other families coped more successfully, according the father authority and esteem independent of his breadwinning powers, and survived without major disruptions. Similar effects may be produced by rapid, upward mobility, by temporary dismemberment (as in war, through illness, or in special work situations), or by permanent dismemberment (through death, divorce, desertion, or imprisonment).

Many other circumstances are capable of precipitating a train of events that alters the family's equilibrium and eventually the health of its members. An unwanted or illegitimate pregnancy; premature birth, serious illness, delinquency and crime, having a retarded child or a very gifted child, political persecution, natural disaster, and many other conditions can be hazards for family life. How great they are as public health problems is difficult to assess since there are so many contingencies between event and outcome, and because few epidemiological studies have focused on the family as a unit.

How many families have problems?

In one sense all families have problems. The notion of a family includes the fact that people age and mature, usually move out of the natal family to form their own conjugal family, and ultimately die. This expectation of a life cycle, in addition to the variation in conditions within which the family lives, does not ensure a pattern of family life that is adaptable once and for all. In the more technical sense of how many families include one or more disturbed members, only estimates can be made. A recent national survey revealed that 23 per cent

of the respondents felt they had at some time had problems for which professional help might have been useful and 19 per cent felt that at one time or another they were going to have a nervous breakdown. It is known too that one person in seventeen will receive treatment in a mental hospital at some time during his life, and that, for every four marriages formed in a given period, one marriage ends in divorce. One estimate has been made that one family in five has treatable disturbance in some member. There are approximately forty-five million families in the United States, so on the basis of this estimate, there would be nine million families with one or more disturbed members.

Does the breakdown of a family or of an individual member occur suddenly?

People involved in a breakdown frequently perceive changes in functioning as occurring abruptly. There is strong evidence, however, that problems and deviant behavior are present far in advance of the situation being identified as a problem. In most families there are tendencies to "normalize" the situation, that is, to redefine discordant behavior so as to place it within an understandable and acceptable view of the person or the group. On a broader level it is known that communities can "close ranks" against "facts" about mental illness that are threatening to them but are not comprehensible to them. One might extrapolate from such evidence that families that do not engage in "normalizing" operations would have dangerously brittle patterns.

Are there clues that indicate disturbed family patterns?

Unfortunately the only reliable clues to family disturbance are its end products—disturbed individuals. Although changed functioning in an individual is not proof of family problems, the relationship between the two is strong enough to warrant attention to the family dimension. In any event, the response of the family to the problems of one member are an important enough factor in the restoration of an adequate level of functioning, or conversely of stabilizing a deviant pattern, for the family to be a focus of consideration.

To evaluate whether or not a family is disturbed requires assessment at various levels: the interaction patterns, the emotional states of its members, and the cultural matrix within which the family and its members function. Bradley Buell and co-workers from Community Research Associates originally proposed a typology of families in terms

of the dominance and adequacy of each parent. More recently they have proposed another typology that distinguishes the perfectionistic family, the inadequate family, the egocentric family, and the unsocial family, taking into account the quality of both intrafamilial and extra-familial relationships. This classification has much to recommend it, but is open to question as to how applicable it is to various culture groups, and how clearly it can identify problem families who have not already been so identified.

One basic problem in delineating patterns that are indicative of poor family mental health is that, except at the extremes, the significance of much behavior depends on how it fits with the whole family "life style," i.e., what functions it serves. The lack of any disharmony, in one family, may indicate a strict repression of any expression of nega-tive feelings. In another, it may indicate that few basic differences exist and those that do are handled in other ways. Similarly the pres-ence of a father who works hard and long may signify devotion and shared sacrifices for mutual benefit, or it may be the father's way of coping with feelings of being inadequate and extruded from the fam-ily, or a means of escape from an unsatisfactory marriage.

On the basis of findings cited earlier, some more specific suggestions might be made. When a persistent pattern of opposing coalitions is present, as for instance, when one child becomes identified as belong-ing to one parent, another to the other parent, and the two sets have separate "lives," this may be a sign of persistent, unresolved tensions. Frequently this breaking up of the family into armed camps can also be seen in relationships with the "outside world" as well, and is re-peated with the extended families, neighbors, and family friends. This is not to assert that everybody should know everyone, see, and treat each one equally—the very existence of such a widespread characteristic as sensitivity about a mother-in-law belies this—but that when divisions become so rigid that there can be no variation in them, regardless of circumstances, problems are likely to be present. The division may operate to the isolation of one individual. When one person becomes the explanation of all frustrations and failures, one suspects that this person has become a scapegoat, a symbol of others' dissatisfaction with themselves and their family life. Alternatively the attempt to maintain a shaky balance may be seen in the placing of unrealistic hopes in one person, as when a wife sees many shortcomings in her husband, resents him, and places all her hopes in a son, who is to become all that his father is not.

Disturbed family relationships are probably more easily seen in the emotional qualities of the relationships. Intense ties between generations especially when tinged with thinly disguised erotic overtones, preserved longer than is appropriate in that culture, are usually a sign of imbalance. The mother who bathes with her sixteen-year-old son is probably inducing him into a sexually deviant role. Such deviant emotional currents are often seen through the behavior adopted to protect the family from full awareness of them. Thus the presence of markedly distorted (or "paralogical" as some investigators label them) modes of coping with impulses or of viewing the world are signs of trouble. Marked shifts of patterns for no adequate, discernible reasons may also be a symptom of family tensions. A few investigations have claimed that disorganization of routines—failures to prepare meals, get children to bed, etc.—are symptoms of the disturbed family. This is not likely to be a reliable clue. When a segment of behavior as specific as this is used as an index of disturbance (but indeed with all the constellations mentioned), much care must be taken to evaluate patterns of feeling and action relative to what the prevailing cultural patterns are, and what ends are served.

Should families seek outside help at the first danger sign of a disturbed member?

Our medical tradition holds that early detection and treatment improve the prognosis. When families are under consideration, this assumption needs to be tempered with consideration of what the implication of seeking and getting outside help is for the family. Workers in child guidance clinics are familiar with mothers who seek help for their children but with the latent intent of proving that their husbands are wrong or worthless. Seeking the help of professionals may signify an oversensitivity to problems that are not unusual or an unrealistic expectation that problems can be solved by merely resorting to an outsider.

Of course, when the disturbance is major, deferring the seeking of help will usually only complicate a problem situation with additional guilt and recrimination. In the light of available evidence it appears that most families err on the side of "normalizing" their perception of the disturbed person (or situation) for longer than is beneficial, so early provision of help (preferably without the implication that something is being "detected") would seem to be in order.

Where do families usually turn for help?

Reading the advice columns in newspapers and confessional articles in magazines gives some idea of the frequency with which family troubles lead people to nonprofessionals. The Joint Commission on Mental Illness and Health, in a recent report on a national sample of individuals, suggests that the proportion of persons seeking help from such sources is small, that the vast majority turn to clergymen, doctors, social agencies, and other recognized sources. This picture contrasts so strongly with journalistic and semiprofessional accounts that one may suspect that the opinion polls have a bias toward "respectable" responses.

Small-scale studies indicate that when a family first becomes aware of problems, it may turn to extended families, work associates, community figures, and the like, before resorting to a professional. Professionals often decry this casting about. However, it should be remembered that some people do not have the cognitive and verbal skills, nor the motivational structure which make it easy for them to relate to professionals. On the whole, an individual's class background has a strong influence upon where he will go for psychiatric treatment, whom he will see, and what kind of treatment he will receive, and what use he and his family will make of it.

Where should families turn for help?

Most communities have family service agencies, outpatient clinics, and similar resources which can be of assistance. A small but increasing number of hospitals have a psychiatric staff available at all times. Some of these programs offer "psychiatric first aid" in the home after the model common in Europe. In addition, many private mental health practitioners are becoming amenable to treating families as units.

Even if there were a sufficient number of professionals competent to diagnose and treat families, a large proportion of people would still take their family problems elsewhere—to ministers, general practitioners, friends, police, etc. There is much to be gained from increasing the skills of such people and encouraging their cooperation with professionals who specialize in mental health problems.

Should disturbed persons be removed from the family for treatment? How does illness affect the rest of the family?

Ideally the decision whether or not to remove a disturbed person from the family unit should be made on the basis of the degree and

nature of the disturbance, the impact of each course on the family, and the availability of resources outside the family. In practice, decisions are usually made on predetermined notions. In the case of disturbed children, some people are impressed by the work of J. Bowlby, R. A. Spitz, and others, which points to the harmful effects of separation from parents. Others are impressed with the difficulties of treating children in an "infectious" milieu and lean toward separation. In the case of adults there is a similar divergence. The general tendency is to hospitalize persons who show disturbance and/or apply for hospital care. In a few areas, however, treatment in homes is being attempted. The experience in the United States with home treatment is scant enough to make generalization difficult, but this system has worked well in Great Britain and the Netherlands. Other evidence suggesting that the issue of whether or not to hospitalize should be kept open comes from studies of the effects of putting cases on a waiting list. When families must wait for hospital space a sizable proportion of the cases are felt not to need hospitalization when space is available.

Whatever the course of action taken, mental illness inevitably affects the whole family. Intact members react emotionally with guilt, hostility, fear, relief, etc. Their emotions frequently complicate interaction patterns already altered by the disturbance and removal of an ill member. Readjustments must be made within the family and also in relation to the outside world. Readjusting can increase stress and lead to breakdowns in others, to withdrawal from the ill member and "closing of the ranks" against his reentry, and to general deterioration of functioning.

Can families be treated?

Families are always treated (or affected) even if treatment of the ill member takes place outside the family and without explicit reference to it. In the child guidance field it has long been commonplace to include the family in treatment procedures. Group therapy has also become common in the past three decades, with some therapists focusing on groups of mothers, or parents. Except for rare pioneers such as J. L. Moreno, it has not been until recently that therapy with family groups has been attempted. Enough experience has accumulated to make it clear that the treatment of family groups is possible and effective, even when the family includes a grossly disturbed person. Further work is needed to determine the strengths and problems of this approach.

If a member is hospitalized, can the family be of help in treatment?

Yes. The family remains a strong force even when a member is removed. There has been widespread neglect of how to use the family effectively, with the result that families are often seen to have nuisance value only. At the same time, it is hard to deny that ties as basic and long-standing as family ties could not be used for therapeutic ends. Professionals have been likely to advise families to accept the physician's authority, and to be at least passively interested, supporting, and cooperative. The wisdom of such advice is difficult to assess. In the Far East families are often brought into hospital care and treatment in a much more active way, with apparently beneficial results for patient and family. Again this is an area in which more guideposts are much needed.

Should patients return to their families when they are released from the hospital?

When patients are ready for release, there is frequent disagreement among hospital, family, and patient concerning where the patient should live. At least two studies have shown that the patient is the most powerful of the three parties, usually getting his way. It is less clear, however, what effect choice of setting to return to has. Parental families tend to be more tolerant of low performance levels than conjugal families, and lower-class families more tolerant than middle-class families. More salient is the finding that posthospital performance is related to what the family expects of the patient. When family expectations are high, performance tends to be high. Another finding is that patients' chances of staying out of the hospital are greatest if they go to live in a nonfamily but group-living setting such as a hostel. Such findings are statistical and consequently difficult to apply to individual cases. They do suggest, nevertheless, that no automatic assumption ought to be made about the appropriateness of returning a patient to his family or the wisdom of taking a former patient back into the family.

Can families safeguard their mental health? Can families be helped toward better mental health?

If we understand the processes in family life which are associated with poor mental health, it would seem possible to extend our knowledge to prevention. Many recommendations are made along these lines,

ranging from the simple—such as attending religious services together, pursuing joint hobbies, and family camping—to the complex—such as extensive family-life education and psychiatric "checkups." While the general aims are laudable, there is little evidence that families are significantly affected by such programs. Often the advice seems to reinforce a particular set of values and advocate patterns of family life accepted by and appropriate only to a particular group. The corrective methods advocated can become new forms in which old conflicts are expressed. To alter the complex and subtle processes which distort personality development is an ideal not yet reachable. Short of the ideal, whatever families can do to get underlying conflicts into the open and to neutralize them, whether by praying together, or fighting together, or consulting a professional together will be a step in the right direction.

At the level of broader social action more concrete suggestions can be made. Since death, disasters, serious illness, unemployment, and other crises frequently precipitate overt problems and lower the ability to cope with them, it would be beneficial to make available competent assistance to families at such times and to reduce the stress-producing potentials of the broader society.

FAMILY PSYCHOTHERAPY

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What is family psychotherapy?

Family psychotherapy is a special method of treating emotional disorders. It is therapy not for one individual alone, but for the whole family. Usually this means father, mother, and children, but it can include other persons who participate within the home in the day-to-day life of the family group. It may, therefore, involve a grandparent, an aunt, or even a maid or a housekeeper.

The psychotherapy of the family unit signifies a radical departure from tradition, a major shift from exclusive preoccupation with the manifestations of mental illness in the individual patient to mental illness as a symptom of family processes.

The psychotherapy of the whole family points its influence to those focuses of disturbance that affect the relations between interpersonal conflict in family relationships and intrapersonal conflict in the family member. It seeks a more favorable balance of force between conflict inside the mind and conflict between the minds of family members.

Individual therapy, or even therapy of family pairs (mother and child, husband and wife), although exerting partial effects on family relationships, does not represent a true family therapy. Such treatment is oriented either to the internal conflict of one individual or is limited to the conflict of a family pair; it is only secondarily concerned with the interactional processes of the family system. The effect of such therapy on family life is indirect and nonspecific. It may help or may harm family relationships. It may bring family members closer together, or, paradoxically, it may intensify the trend toward emotional alienation among the family members.

Until recently, there has not been a true psychotherapy of the family group, only feeble, partial, and substitute gestures in this direction. By the qualifying term "true" is meant a specific method of intervention

that influences the family as an organismic whole, that is based on systematic diagnosis of family behavior, that is focused on distortion of interactional patterns, that copes with the interplay between interpersonal and intrapersonal conflict, and that points its techniques toward the relations between the emotional functioning of the family as a unit and the emotional fate of any one member. Within this framework, it is essential continuously to weigh the equilibrium of forces in family interaction that maintain health or render the members more vulnerable to breakdown and illness.

What is the value of this method of treatment?

Family psychotherapy is a natural level of entry into problems of human relations. It focuses on experiences of conflict, suffering, and disablement, not in isolation, but rather within the network of the person's most significant and intimate relations.

The family can make or break the emotional health of its members. The emotional relations of the individual with his family group exert a profound influence on the tendency of any one member toward health or sickness. These relations affect the precipitation of breakdown and the course and final outcome of the illness. The emotional climate of the inner life of the family may bind a member to his illness, that is, reward him for remaining ill, or it can reinforce his incentive for recovery. (In this sense, the processes of family interaction are a potent force in supporting or discouraging the "secondary gains" of illness.)

The validity of these principles rests on a simple truth, namely, that breakdown and mental illness are products of emotional experience; emotion itself is a social process. Emotion is shared, reciprocated, and contagious. In this special sense, mental illness may be regarded as a contagious and communicable disease. The seeds of such sickness pass from person to person, from one generation to the next. Over a stretch of time, the focuses of the most intense disturbances may shift from one part of the family to another. At any given point in time, the forces that contribute to breakdown can be traced in the contemporary events of family interaction, though at the moment they may be organized and expressed in a pattern that is different from that which prevailed at earlier stages of the family life. The chain of family relations thus represents a kind of conveyer belt, a carrier of sickness-inducing disturbance. But the family also contains and mobilizes the resources for coping in special ways with these areas of disturbance. The struggle to restore emotional health is a shared one in family living. Further-

more, the success or failure of family members in adapting to their respective roles within the group significantly affects their relationships outside the family.

The symptoms of disturbance in one family member not only reflect the impairment of his individual personality, but also represent a functional expression of the emotional difficulties of the whole family. Insofar as multiple members of the group are disturbed, the interaction among them affects the ultimate outcome of their illnesses. The family approach offers potential powers of prevention of mental illness that are not available through other forms of psychotherapy. (See *Prevention of Mental Disorders*)

What are the goals of family therapy?

The goals of family therapy are to alleviate emotional distress and disablement and to promote health in family living:

1) by resolving the components of pathogenic conflict and reducing anxiety
   a) within the matrix of interpersonal relationships
   b) within the individual personalities of family members;
2) by enhancing the harmony and balance of family functioning;
3) by strengthening immunity through mobilization of the resources of the family as an interactional unit and mobilization of the resources of its members, for a more realistic and effective coping with conflict;
4) by orienting family identity and values toward health.

What are the therapeutic tasks?

The therapeutic tasks are:

1) to help the family define the real content of family conflict, through greater accuracy of perception and by clarifying the interpretation of the conflict;
2) to counteract inappropriate displacements of conflict from its original object to substitute objects;
3) to neutralize the irrational prejudices and scapegoating that are involved in the displacement of conflict. The purpose here is to put the conflict back where it came from in family role relationships, to re-attach it to its original source and attempt to work it out there so as to counteract the trend toward prejudicial assault and disparagement of any one member;
4) to reduce excessive conflict in a victimized part of the family, either in an individual or in a family pair;

5) to energize dormant interpersonal conflicts, bringing them out into the arena of family interaction, thus making them accessible to solution;

6) to lift concealed intrapersonal conflicts to the level of interpersonal relations, where they may be coped with more effectively;

7) to activate an improved level of mutual support in family role relationships. (See *The Family in Illness and Health*)

Is emotional communication within the family a serious problem?

In family life, emotional communication can be a serious problem. At one pole, there is the family whose members hardly communicate at all. The group is fragmented; the members are alienated from one another. At the opposite pole, there is frequent contact among the members of the group, but they battle one another continuously in a destructive way and about the wrong things. In such families, the mistrust and hostility is fierce. The members of the family tend to deny or displace the crucial problems. They engage uncritically in harmful scapegoating of one or another member. A loss of emotional control is a constant threat and, now and then, there are outbreaks of physical violence. Occasionally a family oscillates between phases of hostile silence and outbreaks of uncontrolled fighting and violence.

The clinician attempts to maintain a balanced control of these processes of contact and communication. As far as he can, he tries to bring about a useful and appropriate kind of emotional interchange, a live, touching quality of experience in which all the members are encouraged to take part in the struggle to reach and understand the important areas of conflict. The therapist endeavors to avoid phases of hostile, unproductive silence and, at the other extreme, to avoid that utter waste of family life, namely, argumentation about inappropriate or trivial matters.

What is the role of the therapist?

The clinician fulfills the role of a parent or a grandparent. He is interested; he is actively involved. He uses his therapeutic self in a special way. He helps define the areas of family conflict and he confronts the family with them. He elaborates the various expressions of the conflict. He demonstrates the ineffectiveness and the harmfulness of the family's habitual ways of coping with conflict, the sick and destructive forms of control and defense. He stirs an awakening to other avenues of possible solution. He encourages the substitution of healthy

defenses against anxiety for the sick and harmful defenses. When indicated, he injects into the hopper of family discussion more suitable images of family relations and also more appropriate emotions. He supplies the elements of emotional health in which the family was lacking.

The role of the family therapist, therefore, is an active, open, forthright one. For him there is no question of anonymity; he cannot hide his face nor can he be merely a passive listener. He acts as a kind of catalyst or chemical reagent dissolving the barriers of communication, stirring the interactional processes among the family members, shaking up the elements, and promoting a movement toward a healthier realignment of family relationships.

In this setting, the family therapist cannot be emotionally neutral. He follows the movement of the center of sickness-inducing disturbance from one part of the family to another. The core of the most destructive conflict may shift about from mother and child to husband and wife, and, at times, it may settle in an isolated way within the personality of one individual member, such as a child, who is often the pawn of conflict between the parents. The therapist follows along and engages the family members in a process of working out the elements of these conflicts. As he does this, he gives selective support now to this part of the family, now to another.

Throughout this procedure, the therapist seeks to penetrate the sickness-inducing barriers to emotional union and sharing in family relations. He challenges the existing patterns of alienation and fragmentation in the family relationships. He mobilizes action and reaction and energizes the release of hidden conflict material. He may call pointed attention to facial expressions, body postures, movements, etc., and by these means he may expand and sharpen the perception of relevant family conflict. By discretionary use of these nonverbal aspects of intercommunication, the therapist is enabled to challenge unreal and impossible demands, fruitless vindictive forms of blaming, and omnipotent destructive invasions of one member by another. Gradually, step by step, the therapist is able to activate an awareness of new avenues of sharing, new kinds of intimacy, new levels of identification, and to mobilize a realignment of emotional relationships in the family in the direction of improved health.

How does the therapist initiate family treatment?

The therapist does this in a simple, casual, straightforward manner. Regardless of the nature of the complaint and regardless of the

individual member who is tagged with a label, "the sick one," the therapist casually invites the whole family to come in and talk it over.

Regardless of those traditions in family and community living that tend to bring about an indictment of one particular member of the family as the sick one, the fact is that multiple members of the group are emotionally disturbed in different ways and degrees. There is continuous interplay among the family members who are afflicted with these disturbances. Actually the members know that it is not only one individual in the group who is emotionally disabled. Inwardly they know that the whole family is troubled and therefore they tend to be receptive to the method of interview that gives simple, honest recognition to this principle.

As the therapist communicates his understanding of this contagion of emotion and the genuineness of his interest in all family members, the group as a whole generally shows a desire for help. As soon as the members become involved in the live processes of the clinical interview, they quickly tend to lose any initial self-consciousness they may have had.

In the main, the threat of personal exposure is less frightening and less important than the basic urge to be understood and helped.

Do some members of the family sometimes refuse to come to therapeutic sessions?

Yes. Occasionally one member—perhaps a parent or a rebellious adolescent—balks at being involved in this kind of family treatment. When this occurs, however, it generally represents not merely the emotional resistance of this one individual, in isolation, but rather a defensive alliance of the balky individual with some other member of the family. For example, a resistant wife may be allied with her mother against her husband, or a resistant, rebellious adolescent girl may be allied with her grandfather against the authority of both parents. Generally such resistances can be effectively met and dissolved as the therapist identifies this defensive alliance and invites the members of the alliance into the family interview.

In what situations is family therapy useful?

Family psychotherapy has a wide range of applicability, but must be modified to accommodate to different conditions. It can be helpful in those situations where major conflicts are not predominantly intra-

psychic or of long standing. For best possible progress, all members of the family unit need to be involved, for all of them need assurance that the emotional forces supporting union in the family are stronger than the forces pushing toward destruction and alienation.

Family therapy may be the sole method of treatment or it may be used in conjunction with other methods. It can be helpful, even indispensable, as a procedure for involving a sick but resistant family member in a therapeutic experience. It can also be of value during selected phases of individual psychotherapy; for example, it may break the resistance or the bogging down of an individual patient who is exploiting secondary neurotic gains. Thus, it may free him to resume progress in his therapy. Similarly, family psychotherapy can be helpful in the emotional reintegration of a patient with his family in the final phase of his personal therapy.

Family therapy can be of substantial value for disturbances at all stages of the life cycle—childhood, adolescence, adulthood, and old age. It is especially effective in disturbances involving the relations of a child with his family.

When is family therapy not desirable?

Family therapy may not be recommended if there is evidence of an irreversible trend toward disintegration and breakup of the family. For some families, it may be too late to reverse the forces of fragmentation. Another contraindication for family therapy is a dominance within the group of a concentrated focus of malignant motivation. For example, one member of the parental pair may suffer from an organized progressive paranoid condition or from a form of incorrigible psychopathic destructiveness or habitual criminality. One member of a pair may show a form of fixed personal psychopathology that prevents participation in family interviews. Sometimes the rigid defenses of one parent exert an overweening and disintegrative effect on the emotional health of other members. Sometimes these rigid patterns of alienation and the associated barriers to interpersonal communication render intervention with the family therapy method ineffective.

Still another condition that may represent a contraindication is the existence of an unyielding cultural or religious prejudice against this type of intervention in the private affairs of family life.

Finally, organic disease or impairment of a progressive nature that might preclude the effective participation of these individuals in family interviews could be an indication against the use of family therapy.

Can family therapy obtain access to material at deep levels of the psychic process?

Decisively yes. To some clinicians it appears that the family method of treatment is a technique that stays on the surface, and deals with external reality. They see it, in effect, as a form of family counseling that cannot reach the deeper experiences of people, particularly the unconscious sources of their disturbance. Experience indicates that this is not so.

The question of therapy in depth is often misunderstood. Often, what appears to be superficial, trivial, or external, turns out to be not so at all. In the opposite direction, material that is assumed to have a deep unconscious source may represent a misleading and deceptive judgment. Frequently such material is actually very much within the patient's awareness. Again, so-called surface or external or realistic aspects of human experience cannot be considered unimportant.

In family therapy, the therapist can achieve access to any psychic depth that he requires. This depends on his discretionary use of himself in an evocative role in appropriate dealings with clashes of inner and outer experience, unconscious and conscious perception, fantasy and reality, matters involving the individual and matters involving the group. The power to induce therapeutic change derives exactly from a working out of these very discrepancies.

How does the therapist deal with intimate or secret matters and at the same time respect individual privacy?

The therapist is required to distinguish between those forms of secrecy that are sickness-inducing in that they involve a kind of hiding and barricading of emotion that moves toward breakdown, and those other kinds of privacy that are appropriate and that support health. Beyond that, it is his duty to help family members recognize the difference between valid and invalid kinds of privacy. The therapist may, with full confidence, support the healthy, valid types of individual privacy and, by that same token, may move toward enhancing the incentive of family members to challenge and bring into the open the kinds of secrecy that reinforce sickness in family relations.

In family therapy, what is the relation between diagnosis and treatment?

In family psychotherapy, diagnosis and treatment go hand in hand. Naturally, the types of technique employed in family psychotherapy

depend upon the principles of diagnostic evaluation of the pathogenic forces within the family and the relation of these to the emotional disturbance of any individual member. However, a comprehensive diagnosis of the emotional health of the family is something that is achieved stage by stage over a considerable period of investigation. Only a preliminary impressionistic diagnosis of the family is possible within the first few exploratory interviews. In other words, the royal road to systematic family diagnosis is the therapeutic interview process itself. Diagnosis is the foundation for therapeutic intervention, but on the other hand, the therapeutically oriented clinical interview is the path along which a comprehensive diagnostic evaluation of the family group is obtained. The two functions, therefore, are interrelated and interdependent. The one facilitates the other.

What are the strengths, weaknesses, and limitations of family therapy compared to other types of therapy?

The field of psychotherapy in general is today in a state of flux. The bright optimism that surrounded the early discoveries in individual psychotherapy and psychopathology has dimmed. As the techniques of individual therapy have evolved, their limitations have become clearer. In a general sense, individual psychotherapy is effective in the cure of symptoms rooted in intense conflicts of the past, especially of childhood, but is relatively less efficient in coping with the problems of contemporary conflict. The conflicts experienced in the here and now, in the on-going experiences of social interaction with other people, especially with family members, are important factors in maintaining emotional health and in predisposing to mental breakdown. Therefore, specific techniques of therapeutic intervention pointed toward these on-going interpersonal conflicts need to be developed.

It is the increasing recognition of some of the limitations of individual treatment that explains the great spread of interest in the potential powers of group therapy. The more traditional forms of group psychotherapy depend upon an artificial group, an aggregate of sick individuals who are brought together but who have in common only the fact of being treated by one therapist; they are individuals who have not shared previous identity or previous struggles with life's problems. Nonetheless, these forms of group therapy have proved useful in favorably modifying disturbances of identity and certain traits of character. (See *Group Psychotherapy*)

To set one therapy in competition with another would be naïve and unsound. One must recognize that each type of psychotherapy is characterized by certain specific strengths, but also reflects certain weaknesses and limitations. Clinical observation documents the principle that no one method of treatment is sufficient and complete unto itself. No one of these techniques has achieved a sufficient access to all components of disturbance.

To generalize, one might say that psychoanalysis has a favored access to unconscious mental mechanisms and is useful toward the resolution of those components of emotional sickness that have their origin in entrenched forms of childhood conflict. On the other hand, the techniques of psychoanalysis disclose certain selective limitations in the powers of reality testing. To generalize further, group psychotherapy holds the power to modify character traits and ego defense operations, but has limited access to submerged levels of disturbance that are relatively more private and personal. In turn, family psychotherapy reveals certain unique potentials of its own not apparent in the other methods of therapy. It has a special effectiveness in dealing with the social determinants of illness, especially with the component of disturbance that involves the adaptation of the individual personality to family role relationships. (See *Psychoanalysis; Mental Mechanisms*)

Can individual therapy be used parallel with family treatment?

Family psychotherapy does not preclude the discriminating and appropriate use of other methods. Individual psychotherapy, when clinically indicated by the condition of individual family members, may be usefully employed together with family therapy but may be viewed as auxiliary to the family therapeutic approach.

The existence of fixated forms of personal disturbance, closely locked off within the mind of one individual, may require therapeutic intervention at a private individual level. This may be necessary because of the depth and relative malignancy of certain individual components of personality disorder, or it may be required because the locked-off conflict of one member limits the capacity of this individual to participate in the procedure of family therapy. Occasionally, for such an individual, the threat of personal exposure is so intense that it prevents him from taking part in family interviews, or the family structure is too weak to fortify his incentive to take part in treatment of the whole family. Therefore, a special therapeutic support for this individual is needed as an adjunct to family therapy. (See *Psychotherapy*)

Should the same therapist treat the family and a disturbed individual member?

As a general principle, the use of the same therapist for the family and the disturbed individual holds certain obvious advantages in the long view. However, if for one person the threat of exposure is too intense, it may be necessary for him to have a different therapist.

Is family therapy a significant addition to other types of mental health services available in the community?

Without question, yes. A specific therapy for the emotional disorders of the family group, a method of ameliorating the harmful forms of emotional interaction of the individual with his family, fills a critical gap in the pattern of mental health practices. Among mental health workers it is increasingly asserted that society is the patient. Society is parent to the family, and the family is the basic unit of society. The historical approach to problems of mental health through mentally disabled individuals, one by one, is inefficient.

A more strategic procedure is an organized approach to the psychopathological events of family living. Every man begins life with a family. He is part of it; it is part of him. The condition of "belongingness" leaves an indelible imprint. As long as he lives, his relatedness to people bears this initial imprint. Though time may wear it thin, it is never erased. A systematic clinical procedure for diagnosing and treating the psychological disturbances of family living is a significant means for carrying on the battle for mental health.

Who is qualified to do family treatment?

The problems of the family are not the monopoly of any one profession. All interested professional people in the fields of social work, education, psychology, medicine, and psychiatry have a valid claim. Coping with the health problems of the family group is a broad venture in public health. As a matter of sound policy and sheer efficacy, public health services for the family taken as a group call for an integrated health team. Under the best circumstances, therefore, psychotherapy for the whole family might be conducted under the auspices of a public health facility, either a clinic or a family service organization. On the other hand, it is entirely possible that in the private practice of medicine and psychotherapy similar health teams may be formed and may provide their services under the auspices of a private clinic.

Whatever the setting, it is self-evident that the therapist, whether he is identified with medicine and psychiatry, or with psychology or social work, must have adequate training in this special procedure. At the present time an effort is under way to provide systematic and specialized training in the use of this method of treating the whole family.

Where can people obtain these health services?

Since the family method of treatment of mental health problems is relatively new, it is not yet widely available; however, health service of this type is expanding rapidly. At present it can be obtained in some medical centers, and in clinics in the more advanced family service organizations; it is also provided by some psychiatrists and social workers in private practice.

For further information consult a local mental health association, medical society, The Family Institute, or the Family Service Association of America.

FEAR

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What is fear?

Fear is an emotional reaction to an external danger, real or imagined, before which we feel helpless or inadequate. It is a painful feeling consisting of certain physiological changes, the awareness of these changes, and the particular mental sensations that give to fear its special quality.

The amount of fear we experience at any given time depends on the nature of the danger and our ability to meet it. The fear may be mild with alertness, heightened awareness, and sharpened perception; moderate with rapid heartbeat, tremulousness, sweating, and weakness; or severe with panic and disorganization of thought and behavior.

Unless the fear paralyzes us, we try to take some action to diminish it. This may range from the primitive instinctive fight or flight action to more complex planned attempts to avoid, control, master, modify, or otherwise cope with the danger.

What is the difference between fear and anxiety?

Anxiety, like fear, is an emotional reaction to danger. The emotional reaction, the painful feeling, is the same as in fear. The difference is in the nature of the danger. In fear the danger is external and known, in anxiety the danger is internal and usually unknown or unconscious.

How do we explain such an internal danger? As children we had certain sexual and aggressive impulses, wishes, thoughts, or feelings that we were afraid to express. Correctly or not we had the impression that their expression would result in our being deserted, not loved, or punished. In order to diminish our fear, we automatically used an internal action similar to fleeing an external danger. Both the dangerous impulse and the assumed threat became unconscious and the fear disappeared.

Subsequently, however, if either the unconscious impulse or the unconscious threat is reactivated with sufficient intensity, the old danger returns and we experience anxiety as a response to it. Whereas,

it is clear what fear is about, anxiety has a quality of indefiniteness and a lack of object inasmuch as its cause is internal and unconscious. We might say that fear signals a danger in the external world while anxiety signals a danger in the inner world of the person, a danger of which he is unaware. (See *Anxiety*)

Are there different types of fear? If so, what are they?

There are two kinds of fear: first, rational or realistic fear which is an appropriate and intelligible response to a known, conscious external danger; and second, irrational or neurotic fear which is an inappropriate and unintelligible reaction to an external situation or object that is not ordinarily considered to be frightening or dangerous or is considered to be only slightly so. Neurotic fear is the result of another kind of internal action. An unconscious internal danger becomes attached to something external and we are then afraid of this something for reasons that we are not aware of, although we may automatically manufacture what appear to be rational reasons.

Frequently realistic fear and irrational fear are mingled. The danger is known and real, but the fear is excessive. To the known and real danger an unknown internal one has been attached. How many of us experience fear out of proportion to any real danger when we go to the dentist?

Any severe external threat will arouse irrational fear along with rational fear, because the threat activates forbidden aggressive impulses and, partly in response to these, reactivates childhood fears of being unloved, abandoned, and punished.

What is the difference between fear and phobia?

A phobia is a morbid, intense, neurotic fear of some specific external situation or object such as bridges, pets, darkness, conveyances, open or closed spaces, crowds, or heights. (See *Phobia*)

What causes fear?

In the first months of life the infant reacts to outer stimuli, such as loud noises, or inner stimuli, such as hunger, with diffuse emotional spells that we assume to be painful. As time passes he learns that certain stimuli or situations will bring on such a painful state of physiological tension. He learns to fear and avoid such stimuli. However, hunger cannot be avoided. It requires his mother's presence to relieve it.

Therefore his mother's absence causes fear, fear that hunger will become intolerable.

These are the beginnings of what we fear in adulthood. From being oblivious, as in infancy, to most external dangers, we come to know what is dangerous in the physical world. In the psychological realm matters are more complicated. Each developmental stage has its own major fear. We proceed from the fear of mother's absence, to the fear of the withdrawal of mother's loving care, to the fear of the withdrawal of love, to the fear of physical injury, to the fear of punishment, and finally to the fear of our own conscience.

All of this brings us to fear many things in adulthood. We fear harm or injury to ourselves or to our loved ones. We fear disapproval, loss of love, and punishment. We fear failure, economic loss, and loss of prestige, position, or reputation. What is feared is the loss of something loved and highly prized whether it is our own person, another person, an inanimate thing, or an abstract idea. To these realistic fears we add the manifold neurotic fears that can attach themselves to any external situation or object.

However, it is not only the external threat that frightens us, but also our helplessness in the face of it, for fear is our anticipation that a situation in which we previously felt helpless is about to recur. As would be expected this sense of helplessness is more marked in neurotic fear where the reason for the fear is neither known nor understood.

How are aggression and hostility related to fear?

Fear and aggression are closely and reciprocally interrelated. This is not surprising in view of the fact that they have common biological and physiological roots in the primitive, instinctive fight-flight reaction. When we are threatened, we may attempt to flee—with accompanying feelings of fear—or we may attempt to attack—with accompanying feelings of rage. In turn, we may fear retaliation for our attack and rage. (See *Aggressions*)

Fear and hostility are related in other more complex ways. We may attach our unacceptable inner hatred onto something outside ourselves and then fear this something. For example, a little girl who was angry with her mother developed a fear of witches. Or in the reverse direction, we may attach the frightening anger of someone who threatens us onto ourselves and become angry and threatening like that person as a way of overcoming our fear of them. For example, the little girl sometimes played that she was the angry witch.

Is the fear of death the basis of all fear?

No. The child develops all the fears we have described before he begins to understand death. We fear what we have learned to fear through experience, but we have never experienced our own death. Thus the fear of death is experienced in terms of previous dangers such as hunger, separation from mother and loved ones, loneliness, the absence of love, and punishment. When death threatens we may make an effort to be good, reacting to the threat as if it were a punishment.

How has man dealt with the fear of death?

The fear of death increases with age. As some of our loved ones, but especially our peers, begin to die, the reality of death draws closer. A serious accident, particularly when we narrowly escape death, makes this danger more real to us. Normally, we put the fear of death out of our minds, but these events make our constant denial of death, our belief in our invulnerability and omnipotence, harder to maintain. The attempt to cope with this fear and to understand the mystery of life and death has been a major force behind the development of magic, religion, philosophy, science, and medicine. Fear of the danger of extinction played a major role in first binding human groups together for mutual security.

What are healthy reactions to realistic fear?

Realistic fear signals danger and prepares us to meet it. In order to cope successfully with and tolerate danger, it is necessary to go through what we might call an emotional inoculation against the intensity of the fear, to engage in what is called the work of worrying. This consists of fully anticipating all aspects of the impending danger situation, learning all that there is to be known about it, and making all the necessary preparations. Learning about it will make us more familiar with what is to come and will offer an opportunity to find reassuring facts that may counter any tendency to overemphasize the dark side of things. If other people are involved in meeting a common danger it is important to work together, to prepare for action with a common purpose with a trusted and capable leader.

Are certain fears necessary for the healthy functioning of the individual?

Neurotic fear hinders; realistic fear—up to a limit—helps functioning. In circumstances of real physical danger fear causes our muscles to

tense, our livers to provide extra sugar for energy, our hearts to speed up, and our minds to be more alert. In response to fear we mobilize and intensify our capacities toward a higher level of functioning and learning and toward new forms of adaptation.

What are unhealthy reactions to realistic fear?

Overreaction or panic, and underreaction or denial, are unhealthy responses to fear. Panic occurs when fear becomes so intense that it fails in its psychological and physiological functions. Instead of mobilizing resources for flight or defense, it has a paralyzing or disorganizing effect.

Denial is an internal action that avoids the feeling of fear by denying to conscious awareness the existence of an impending danger. Inner preparation does not occur and this makes the reaction more extreme once the inescapable danger is encountered and denial no longer works. Inasmuch as the person has also denied the seriousness of the matter, after the event he is more likely to feel helpless, victimized, hurt, and angry.

What determines how a person is going to react to real danger?

First, his personality predisposition. Is he going to add neurotic fears to real fears? Has he developed good methods of mastering and coping with fear? Second, has his preparation been adequate? Third, what is the nature and severity of the danger? Is it something known and tangible against which action can be taken? Or is the person left passive and helpless? If he is a member of a group, e.g., a soldier, is the leadership and morale good?

Is freedom from all fear a desirable goal to strive for?

Definitely not. Without fear man could neither survive, learn, nor become civilized. The goal to strive for would be an absence, insofar as possible, of irrational or neurotic fear on the one hand, and a healthy, constructive reaction to those real danger situations and fears that are a part of life, on the other hand.

Is the ability to control fear a sign of mental stability?

Yes. Though frightened, the person in control would not become disorganized in the face of danger.

How do children first experience fear? Is this necessarily a traumatic experience?

We have seen how the unpleasurable physiological tensions in the infant become differentiated into fear, if the danger is external, and anxiety, if the danger is internal, and how the growing child learns what outer and inner situations are dangerous. Since this differentiation and learning are part of normal maturation and development, the first experiences of fear are necessary and would be traumatic only if they were excessive or if the child was not helped to master the usual childhood fears.

Are these early fears likely to have lasting effects on the personality— such as making the adult an anxious or timid individual?

The future mental health of the child does not depend only on the presence and severity of early fears, but also on the child's solution of these fears. If the solution is a poor one, he may become anxious; if it is successful, he will become courageous, not timid.

Do parents promote the development of unnecessary fears in their children?

Yes, they often do; for example, by behaving in a frightening manner with use of threats that reinforce the child's ordinary fears; or by being unduly seductive, stimulating, or punitive; or by reacting to danger with panic or denial, which inclines the child to do the same.

How can parents avoid arousing fears in their children?

Parents should not want to avoid those fears *necessary* for normal development. How else can a child learn what is dangerous and how else can he develop a conscience? Nor can *unnecessary* fears be completely avoided even in the best parent-child relationship. They seem to be an invariable accompaniment of becoming civilized, resulting from the conflict between the child's impulses (love and hate), between the child's impulses and external controls and forces (parents and reality), and between the child's impulses and his internal controls (conscience) once these internal controls are established.

Nor do we by any means know everything about how children should be reared in order to avoid unnecessary fears. We can only add a few words to what has been said. Many simple fears can be subdued with reassurance and explanation. Sometimes fear expresses itself as some-

thing else such as apathy, avoidance, or stubbornness. It is important to recognize and understand the underlying fear in order to help the child with it. Discipline if too lax will not help the child learn to tolerate small but increasing amounts of frustration and fear. If too strict it may lead to excessive fear in connection with learning controls.

What is the explanation for cowardice and for the seemingly fearless individual, for example, the soldier who repeatedly and voluntarily risks his life?

When neurotic fear increases the burden of realistic fear sufficiently, it can lead, in certain circumstances and in certain people who cope with fear poorly, to panic and cowardly behavior.

Another person may attempt to overcome his neurotic fear by being unnecessarily and recklessly courageous in the face of outer danger. By overcoming the outer danger, he attempts to prove to himself that there is no inner danger. This behavior, as with cowardice, is dictated by inner unrealistic considerations and not by a correct appraisal of the external danger.

Can soldiers be helped to control fear in combat?

Yes, by helping them develop healthy reactions to fear. The repetitive anticipation of danger fulfills the function of pushing back the borders of the unknown, of replacing fantasy with reality, so that inner fears are dispelled and defensive action and preparation can take place.

Are persons who are more imaginative likely to be more susceptible to fear?

No. The healthy use of imagination can make us less susceptible to fear by offering us an outlet in fantasy, in play, and in the arts and sciences for impulses that otherwise might create anxiety and neurotic fears.

What creates fear is not the use of imagination but the confusion between imagination and reality. If we believe what we imagine to be true, we will be frightened. If we attach our inner irrational fears to outside situations or objects, they will frighten us.

Is fear at the heart of most social disturbance?

In the group, as in the individual, fear first of all signals danger rather than causes it. The group's reaction to danger, as with the in-

dividual, may be healthy, e.g., greater group cohesion with the threat of war, or unhealthy, e.g., panic in response to a natural catastrophe. Panic can spread as the result of contagion, can bring on paralysis or disorganized behavior, and can lead to a breakdown of social organization.

Is fear at the root of most mental disorders?

Most of us agree with Sigmund Freud's assertion that anxiety is the central problem of mental illness. Mental symptoms and mental illness are simultaneously the expression of unbearable anxiety and attempts to cope with and ward off the anxiety as in phobias and neurotic fears. Reduction of fear is essential in the successful treatment of mental disorders.

Realistic fear can ordinarily be dealt with satisfactorily and will not cause mental disorder. However, under extreme circumstances of stress, such as combat, a traumatic neurosis may develop.

Are some fears a direct result of mental disorder?

Just as it is frightening to become aware of a serious physical illness or suddenly to be aware of an inability to perform a simple task because of brain damage, it is frightening to sense the impending personality and mental disintegration of serious mental disorder.

What might be the psychological or physiological outcome of the continued action of fear?

If our attempt to diminish fear and anxiety by outer or inner adjustments, including neurotic symptoms, fails, certain acute and chronic symptoms may occur—such as tension, attacks of anxiety, emotional spells, and physiological changes. The latter, if chronic, may in turn contribute to the development of a psychosomatic illness.

What treatments are available for dealing with neurotic fears? How successful are these treatments?

The choice and success of treatment, whether it is shock therapy, drug therapy, psychotherapy, or psychoanalysis, will depend on many things about the person who has neurotic fears—such as his age, his life situation, the nature and severity of his emotional or mental illness.

SIGMUND FREUD

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Who was the founder of psychoanalysis?

Sigmund Freud, generally considered one of the outstanding thinkers of the twentieth century, was the founder of psychoanalysis. His concepts of the human mind have revolutionized man's ideas about his own nature and about the institutions man has created. For Freud, psychoanalysis was more than a method of curing certain nervous disorders. It was also an instrument for research and a basic science of human behavior. Freud's psychoanalytic principles have influenced medicine, psychology, the arts, and social sciences. In the words of the Anglo-American poet, W. H. Auden, Freud has become "part of the climate of our time."

Sigmund Freud was born in the small town of Freiberg, in Moravia, on May 6, 1856, of Jewish parents. His father was a merchant of moderate means. When Freud was four years old, his family moved to Vienna. It was in Vienna that Freud lived, received his education, married, practiced medicine, and made his discoveries in psychoanalysis. He left Vienna the last year of his life, when as a refugee from the Nazi terror, he moved to England.

Freud's brilliance as a student was recognized from his earliest school days. He was free to choose his own profession and his interests ranged widely through law, politics, general science, and medicine. He finally chose medicine although biological research was his primary interest. In 1873 he enrolled at the University of Vienna, where, as he later wrote, the anti-Semitism he encountered taught him what it meant to be a member of a minority. This experience strengthened in him the tendency for independence of thinking, a quality that characterized him for the rest of his life.

In his *Autobiography* (1925) Freud mentions several teachers whose ideas and personalities made a lasting impression on him. The first of these was Ernst Wilhelm von Brücke, the professor of physiology in whose laboratory Freud served as a research assistant from 1876 to 1882. This laboratory was the center for a distinguished group of

scientists who subscribed to the evolutionary ideas of Charles Darwin and the physicalist or materialist theories of Hermann von Helmholtz. Fundamental in the viewpoint of this group was the attempt to understand all biological phenomena in terms of physics and chemistry. Freud brought both the evolutionary theories of Darwin and the materialist theories of the school of Helmholtz into his psychological conceptualizations.

Since this article is devoted, primarily, to the development of Freud's thinking and how his theories influenced mental health, only passing reference will be made to some of the fundamental contributions Freud made to other fields of science. He studied the anatomy of the medulla, published classic essays concerning cerebral paralysis in children, and disturbances of the function of speech in brain-injured persons. In addition, Freud suggested the use of cocaine as a surface anesthetic but, distracted by personal matters, he delayed performing the crucial experiments which brought immortal fame to his friend and colleague, Carl Koller.

Freud's psychological investigations began after a historic conversation with Josef Breuer in 1883. Breuer, an eminent physician and physiologist whom Freud had met in Brücke's laboratory, described a unique and novel method by which he had relieved the symptoms of a woman suffering from severe hysteria. When he placed the patient into a hypnotic trance and made her relate what was oppressing her mind, she would frequently recollect some highly emotional fantasy or event connected with the onset of her symptoms. In the waking state, the patient was completely unaware of the "traumatic event" or its connection with her disability. As the patient recollected these painful experiences in increasingly lighter hypnotic trances and reacted to these recollections with an amount of emotion appropriate to the nature of the events, the symptoms disappeared. These observations made a deep impression upon Freud. He repeated the experiment on several patients during the following twelve years and became convinced of the validity and significance of Breuer's findings. In 1895, mainly as the result of Freud's initiative and insistence, Breuer and Freud published *Studies in Hysteria*.

How did Breuer and Freud account for the origin of hysterical symptoms and for the effectiveness of their therapeutic measures?

It was clear, they argued, that the forgotten memories and emotions persisted in the mind, although the patient was unconscious of

their existence. When the patient recollected the repressed events and discharged the pent-up emotions, the symptoms disappeared. Accordingly Breuer and Freud reasoned that the symptoms of hysteria are the effects of an undischarged quantity of emotion connected with a painful memory. Normally such memories do not cause trouble because the emotion connected with them is either discharged in conscious activity or is gradually integrated into the mind by association with other memories. In hysteria these reactions do not take place because the painful memories have in some manner been split off from the rest of the mind. Thus, there existed simultaneously two areas or levels of mental functioning; a conscious level and an unconscious level. The task of treatment, they concluded, was to transform the repressed memory into a conscious experience and thereby achieve discharge of the pent-up emotions.

Breuer did not pursue these problems further; Freud did. In response to the question, "Why are certain memories forced out of consciousness?" Freud answered, "The motives for repression are defensive, i.e., repression serves to protect the individual from shame, guilt, fear, humiliation, or other unpleasant affects associated with the memory of certain events."

What was the usual nature of the repressed traumatic events?

Clinical experience demonstrated that in practically all cases of hysteria, these traumatic events were sexual in nature, usually stemming from the period of the patient's childhood. In his early clinical material Freud was impressed with the uniform manner in which patients suffering from hysteria reported that they had been seduced sexually at an early age. For a while he regarded this type of experience as an essential factor in the cause of hysteria. Later observations convinced him that in many instances the reports of experiences of seduction, which he had accepted at face value, had actually been fantasies in the mind of the patient when he was a child. At first Freud was bewildered by this turn in his investigations, but he soon came to realize two important conclusions from this and other data: first, that in the minds of patients, fantasies may exert an influence as effective as real events, and second, that contrary to the notions current at the time, children do seem to have sexual wishes and urges.

Did Freud introduce major changes in methods of mental therapy?

Working alone in what he called his period of "splendid isolation" (1895–1905), Freud did introduce major changes into his

methods of therapy. He abandoned hypnosis because many patients could not be hypnotized and because those who could, often became too dependent upon the therapist. Instead he devised a situation in which distractions and external influences upon the patient would be minimal. In addition, he asked his patients to tell freely and without censorship whatever crossed their minds. He anticipated correctly that under such conditions the persistent internal pressure of the un-discharged emotions and unconscious wishes would make themselves apparent in a variety of psychological products.

Many important discoveries followed the introduction of this new technique, known as "free association of ideas." Freud learned that other psychoneurotic symptoms, e.g., phobias and obsessions, also had meaning. He discovered that his method could reveal hidden meanings in many normal phenomena, such as dreams, slips of the tongue, lapses of memory, jokes, artistic creations, fairy tales, and religious rituals. All these had the following characteristics in common: they represented the results of the interplay between two conflicting sets of forces in the mind. On the one side are the un-conscious wishes seeking fulfillment in thought or action. Opposing the expression of these tendencies is another set of forces, representing moral standards, self-interest, and realistic considerations. The conflict of forces ends in a compromise. In these various mental acts the wishes are fulfilled, but only partially and in a substitute form, disguised, distorted, and unrecognizable. Some of these compromises, like symp-toms, are painful and unacceptable; others like dreams, may even be quite pleasurable.

How did the interpreting of dreams become one of the most useful tools in Freud's investigations?

By understanding the dreams his patients reported, Freud enabled them to recollect or reconstruct the experiences of childhood and the wishes that had been of critical importance in shaping their personali-ties and in precipitating their illnesses. From this information and from other data, he evolved a new and revolutionary concept of human sexuality, treated in *Three Essays on Sexuality* in 1905. Only three important features will be mentioned here:

1) Sexuality begins in earliest infancy and not at puberty, as was formerly thought. Childhood sexuality is capable of the widest de-velopmental variation as the result of experiences and the influences of the environment.

2) The sexual feelings of childhood reach a climax around the ages of three to six, in a special set of conflicts over attachment to one's parents. These experiences, known as the Oedipus complex, play a major role in shaping the personality of each individual.

3) In each person there is a competition between the amount of love available for others and for oneself. An overwhelming involvement in self-love is an essential feature of the disturbance in psychosis.

These observations served as a starting point for unraveling the psychology of insanity, and established the basis for an approach to treating certain psychotic patients by psychological methods.

Does this mean that the unconscious and sexuality were all that mattered in Freud's view of human nature?

This is certainly not the case. Freud went on to show how unconscious guilt feelings and moral demands may be as implacable and persistent in their effects, as are sexual urges. He was also impressed by the subtle, inexorable operation of aggressive and self-destructive tendencies, as well as by the disruptive influence of anxiety on the functioning of the mind. All these different trends work in the mind in constant interaction with each other. The role of the ego, which acts as the executive officer of the mind, is to moderate between the conflicting demands of the instinctual impulses, the moral principles, and the realities of life. According to Freud, the goal of treatment, like the goal of education, is to make the ego the rational, civilized master over the irrational forces in the mind and in society. Psychoanalysis has been summed up as "human nature seen from the viewpoint of conflict."

What are the implications of Freud's work on psychology?

In order to answer this question the main features of Freud's contributions may be summarized as follows:

1) Freud introduced the principle of psychic determinism. By this is meant that he tried to apply the same principles of cause and effect used to understand the physical world, to study the phenomena of the mental world.

2) The analytic situation mentioned previously constitutes the closest approach to a controlled experimental situation in which one may observe the functioning of the human mind as determined by its inner forces.

3) Freud demonstrated that many important functions of the mind take place outside the realm of consciousness. These forces are not quiescent. They exert a continuous dynamic effect upon the mind. Freud showed how these effects may be traced back to their unconscious sources. This dynamic view of mental functioning is the basis of most systems of psychotherapy.

4) Freud held the developmental or genetic point of view. This principle of his thinking relates to the concept that an individual's current life situation, his achievements, his mental illness, his total adaptation, must be understood in terms of his previous history, in terms of the interaction between his inborn constitutional tendencies and endowments, on one hand, with the effects of experience and environment, on the other. The past is always to be found in the present, and the experiences of childhood are especially important in shaping the normal personality and in the predisposition to later neurotic illness.

What were the effects of Freud's work on mental health and treatment?

1) There can be no question that Freud takes his place in history as one of the great liberators of the mentally ill. By insisting that the symptoms and the verbal productions of neurotics and psychotics had a meaning, he served to dispel a deeply rooted prejudice directed against a very considerable segment of humanity. This prejudice, entertained inside as well as outside the medical profession, had served to stigmatize neurotic patients and to place them rather beyond the pale of professional sympathy.

2) Freud's theories and technical discoveries made possible a rational system of treating many mental disorders by psychological methods. Even in those instances where psychoanalytic technique is not effective in curing the illness, psychoanalysis still enables the doctor to understand the nature of the patient's complaints and difficulties.

3) Knowledge of early emotional development and its significance in shaping the personality have influenced the theories and practices of educators. It is also important in devising measures for the prevention of emotional disorders and delinquency.

4) Freud's insights into the psychological bonds that unite people into groups and organize their activities around common ideals have

been applied to the study of many problems in sociology and anthropology. These insights also have made possible a form of psychotherapy in which patients may be treated in groups instead of individually. Thus, more persons may benefit from the effects of intensive psychotherapy.

5) Freud's theories have made clear some of the emotional interactions in religious and artistic experience. To a certain measure this makes it possible to exploit systematically the therapeutic effects which religion and art can exert upon the individual.

What has been the effect of Freud's thinking on the individual, the family, the community, and the world today?

It would be very difficult from so close a vantage point in time to estimate the full impact of Freud's thoughts upon our civilization. Freud himself expressed it poetically when he said that he belonged to that group of persons who had disturbed the sleep of the world.

Since Freud, man's view of himself and his institutions has changed in a fundamental way. Psychoanalytic knowledge of unconscious motivation and of the effects of childhood impressions has served to dispel many illusions previously entertained concerning the nature of man, the family, the social order, and the psychological roots of religion.

Freud's theories placed man within the framework of nature, not only biologically but also psychologically. The significance he ascribed to the biological drives, which many considered the "baser" elements in human nature, challenged the accepted and popular view. In addition, the fact that behavior may be determined by "unconscious" forces, forces that may be moral or immoral, sexual or aggressive, self-seeking or self-destructive, has raised many problems in the minds of religious leaders, criminologists, educators, and sociologists. To give but two examples: First, the manner in which offenders and delinquents are judged and treated in the courts and penal institutions has been radically affected by Freud's contributions. Second, the administration of public welfare and charitable work has changed completely as a result of Freud's teachings. The writers and poets of the generation since Freud have been deeply influenced by this new insight. It has served not only to inspire new forms in art and literature, but it has also engendered in many authors a different view of man and of the nature of moral responsibility.

Did Freud encounter much opposition to his ideas when he first proposed them and while he worked on them?

From the very beginning Freud encountered considerable opposition to his ideas. In fact, the response to Freud's revolutionary concepts would make an interesting chapter in the history of science.

Some of the reasons for the opposition to Freud's ideas have already been mentioned, but there were, and still are, other reasons. The first, the earliest, and the most persistent set of objections may be called the "organicist" view. According to the organicists, physical symptoms must have a physical cause. Hysteria causes physical symptoms; therefore, they argued, there must be some physical source of the illness. The notion of psychological origin of hysterical symptoms was to them unthinkable. The argument that hypnosis, a psychological state, could reproduce all the symptoms of hysteria they dismissed offhand. The organicists were not influenced by the absence of any physical, pathological findings in cases of hysteria.

Some philosophers objected to the concept of unconscious mental processes. For them, thought and consciousness are indissoluble. Not to be aware of one's own mental processes was an idea they found utterly unacceptable.

The importance of the sexual drive and the frankness and scientific objectivity with which Freud approached this problem offended the prudish. It is perhaps a measure of Freud's influence upon our mores that it is hard for us to project ourselves backward in time to the Victorian attitude which refused to acknowledge publicly that people may have problems of a sexual nature.

The deterministic qualities of Freud's scientific approach to the study of psychology were perceived as a threat by moralists and religious teachers. They regarded his views as dangerously materialistic.

Whether his ideas were accepted or rejected did not deter Freud from the pursuit of his investigations. In characteristic fashion he applied the principles of psychoanalysis to understand the storm of opposition that blew up about his discoveries. He compared the motives for this opposition to the forces that opposed the discoveries of Galileo Galilei and of Charles Darwin. Like these other great discoverers, Freud and his ideas placed mankind in proper perspective within the framework of nature. He felt that his theories offended man's narcissism and sense of grandiosity. First Galileo had said that man's world was not the center of the universe. Next, Darwin suggested that man was not the final perfect product of divine creation, and now Freud, with his

theory of unconscious motivation, asserted that man was not the conscious master of his own mental house.

How did Freud's ideas become accepted?

In spite of the opposition to Freud's theories, many individuals were deeply influenced by them. The books on hysteria, on dreams, and on the psychopathology of everyday life, made a deep impression on many serious students of psychology and psychiatry. In Burghölzli, Switzerland, one of the outstanding psychiatric clinics of the day, Eugen Bleuler and Carl Jung received Freud's discoveries with enthusiasm. They repeated some of his experiments, applied his principles to the treatment of patients who were insane, and devised new methods to confirm Freud's discoveries. Karl Abraham in Berlin, Sandor Ferenczi in Hungary, Ernest Jones in England, Wilhelm Stekel and Alfred Adler in Vienna, as well as Abraham A. Brill in America, all came to know Freud's teaching, first through his writings and then by coming to Vienna to study with him. In 1910 the International Psychoanalytical Association was formed, and a periodical devoted to the new science was founded. What was striking about the dissemination of Freud's ideas was the effect they had upon poets and writers. D. H. Lawrence, Thomas Mann, and artists of the school of expressionism were influenced by Freud's writings.

Who were Freud's pupils and what role did they play in the evolution of his theories?

The group that gathered around Freud during the early years was composed of avant-garde intellectuals and scientists. Many of these soon developed new theories concerning the functioning of the human mind. Some felt that these new ideas were psychoanalytical in nature, while others established new schools of their own. Alfred Adler and Carl Jung were perhaps two of the best known of Freud's early followers. Adler was impressed by the role which some inferiority of the body-build may play in shaping the psychology of the individual. Jung applied Freud's ideas to the study of schizophrenia. He noted the similarity between the contents of certain schizophrenic delusions and the universal myths of mankind. He felt that these phenomena could be accounted for in terms of a "collective unconscious," that is, an inherited, unconscious store of myths and racial experiences. Freud rejected his ideas as being too mystical and religious.

Otto Rank felt that the principal developmental force in shaping

personality was the experience of separation, and he devised technical procedures and a body of theory that reflected this interest.

Therapeutic innovations were also introduced by Ferenczi, who suggested that it was important to educate and to love the patients in order to get them well. A rather extreme development from Freud's teachings was the "orgone" theory advanced by Wilhelm Reich. He treated some of Freud's concepts concerning the nature of libido in a material way and developed what was essentially a concretistic, physiological approach to the problems of neurosis.

From Freud's investigations about the relationship between bodily function and unconscious motivation grew the field of psychosomatic medicine. G. Groddeck, Smith Ely Jelliffe, Felix Deutsch, and Franz Alexander made contributions which were fundamental to this new field of medicine.

Several groups, whose views diverged from Freud's fundamental teachings, nevertheless, based their main assumptions on his theories. The so-called "cultural" school of psychoanalysis, e.g., Karen Horney and Abram Kardiner, minimized or denied the significance of inherent biological drives in shaping personality and felt that the major causes of personality development and neurosis were traceable to the interaction of the individual and his society.

Finally, mention should be made of Harry Stack Sullivan, founder of the "interpersonal relations" school, who tried to define mental illness in the context of Freud's theories by stressing the causative effect of disturbance in interpersonal relationship and communication. Robert Waelder demonstrated that in each instance one could discern that the divergent viewpoint put forth by some of the individuals mentioned above represented an overemphasis or a special accentuation of one or more of Freud's original ideas.

Abraham A. Brill was responsible for the introduction of psychoanalytic knowledge into America, while Karl Abraham established the first institute for professional training in psychoanalysis. Otto Rank and Hans Sachs developed Freud's psychoanalytic ideas concerning art and literature. Theodor Reik and Oskar Pfister did the same for religion.

How did Freud spend the last part of his life?

Freud lived and worked quietly in Vienna until the last year of his life. In 1909 he was invited to deliver a series of lectures at Clark University in the United States. It was his first and only trip to

America, a land that did not impress him. Freud received great rec-
ognition in his later years; in his opinion, the most esteemed honor
was the Goethe prize for literature.

The last sixteen years of his life were marked by a truly heroic
struggle against a cancer of the mouth. His illness caused him agonizing
and intractable pain, but Freud bravely carried on his investigations
until the very end. In 1938, when the Nazis seized Vienna, Freud's
name was prominent on the Nazi proscription list. Only the interven-
tion of the American Ambassador to France, William Bullitt, and of
Princess Marie Bonaparte secured his safe release to England. He died
in September 1939 in England, a land he had long admired and yearned
for from afar.

FRIGIDITY

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What is frigidity?

Frigidity is the inability of a woman to experience orgasm, but a broader meaning is failure to derive *any* pleasure from sexual intercourse.

What is the nature of the orgasm in woman and where is it felt?

Sexual stimulation leads normally to an intensity of sexual tension and excitement followed, during intercourse, by a more or less sudden release and relaxation. The moments of release, which may be ecstatic and dramatic or may be more quietly gratifying, constitute the orgasm. The focal point of the response may be at the clitoris, or in the vagina, or "all over." The ideal of orgastic response is often taken to be an intense vaginal orgasm, but outstanding authorities such as Helene Deutsch question whether the absence of such response constitutes frigidity. In her view, the clitoris is the organ of sexual excitement while the vagina is a passive-receptive "sucking" organ at the service of reproduction. The most feminine response of the vagina, in her view, is alternate sucking and relaxing during intercourse, followed by mild, slow, relaxation and a sense of complete gratification at the end. In short, there is still considerable difference of opinion as to what constitutes orgasm and where and how it is felt.

Is there a higher degree of frigidity in women than of impotence in men?

Apparently so, but there are many unknown factors. According to the Kinsey reports, there is a very high incidence of frigidity in the early years of marriage, but almost no impotence. After twenty years of marriage, however, there is considerably less frigidity, but an increasing rate of impotence. Overall, however, there is more frigidity than impotence—at least up to the age of fifty. It must be added, however, that estimates of the incidence of both of these conditions vary widely, that much depends upon age and experience, and that still more depends upon how the terms are defined; for example, if gratifica-

tion rather than orgasm is the criterion, there is considerably less frigidity than most statistics (including the Kinsey reports) indicate. (See *Impotence*)

Is there any age-group in which frigidity is more prevalent?

The Kinsey report indicates that the longer a woman has been having sexual intercourse, the less likely she is to be frigid. The incidence is highest in women married less than a year and lowest in women married twenty years or more. Thus, the elements of experience, confidence, adjustment to the partner, and a host of other factors are probably more important than the single factor of age. (See *The Aging and the Aged*)

Is there any relationship between frigidity and the degree of education a woman has?

According to the Kinsey report, there is a direct relationship between educational level and sexual gratification, particularly during the first year of marriage. There are fewer cases of absolute frigidity in college graduates than in women who have only finished the eighth grade. The high school group is in between.

Are there certain cultures in which frigidity is more prevalent?

Yes. The phenomena of love and of lovemaking, and the techniques and goals of sexual intercourse vary markedly from culture to culture. There are cultures in which orgasm is not expected and indeed even disapproved. The same may be true in segments of American culture where Victorian standards persist.

Do the majority of women go through periods of frigidity during their lives?

Certainly the majority of women have episodes of frigidity. The first months or even years of marriage are a period of frigidity for many. Women may be frigid for a time after childbirth, when worried about another pregnancy, when living with relatives, when upset about finances or other domestic problems, and so on. Frigidity may accompany the menopause, but by no means necessarily does so. A period of upset for a husband may result in a period of frigidity for his wife.

Is the incidence of frigidity increasing or decreasing, and why?

The Kinsey research group found a striking decrease in the incidence of frigidity over a period of forty years. They attributed this

change to more natural attitudes about sex, rising educational level, and related psychological and sociological influences. There are adverse factors, however: the tensions of urban life, fear of nuclear war, confusion of sexual roles, and paradoxically, the very striving for the sexual goal of simultaneous orgasm. Relief from Victorian inhibitions may only be followed by the anguish of striving for perfectionistic standards of pleasure.

Is the rate of frigidity higher in American women?

There is no certain answer to this question. We have seen that questions of definition and of the length of sexual experience are important variables. One has to relate the question to subcultures as well as to cultures, and to subgroups within whatever group is studied. Even in the United States, estimates vary from 8 per cent to 90 per cent.

How has society's attitude toward frigidity changed in recent times?

Frigidity is increasingly regarded as a problem, rather than as a mark of virtue or something to be taken for granted. Increasing sexual knowledge and freer discussion of sexual relations have caused women to expect sexual enjoyment and men to assume greater responsibility for providing it. Modern women are likely to be intolerant of frigidity, but as indicated previously, they may demand more than the biological organism can provide. (See *Sexual Relations and Marriage*)

What is the nature of the anxiety or other feelings that may arise in a husband as a result of his wife's frigidity? What effect does this have on the wife?

When a husband expects to gratify his wife, he is likely to be anxious when he fails. He questions his own adequacy and wonders if his wife will reject him. Or, he doubts his masculinity and tries harder, often with increasing frustration. He may project these feelings and blame his wife for humiliating or "castrating" him. The wife, on her part, will react to her husband's upset. The result can be a mutual interaction of anxiety, guilt, humiliation, a sense of rejection, and defensiveness with the wife becoming more frigid than before and the husband more upset.

Can a frigid wife cause physical and/or mental disorder in her husband?

It is perhaps more accurate to ask whether the husband can make himself sick over her frigidity. The reactions of a husband to a frigid

wife will depend in considerable measure upon his stability. An unstable man, unable to find any other solution for his frustration and sense of failure, may become "sick with worry"—physically or neurotically. The illness, when it occurs, is not due to sexual frustration per se; rather, it is due to a host of conscious and unconscious emotional conflicts within the husband himself.

Can frigidity in a wife cause impotence in her husband?

Yes, but only if the husband is already vulnerable because of sensitivity to sexual rejection or other loss of self-esteem. He may also become impotent from rage and a conscious or unconscious vindictiveness.

What are the physical causes of frigidity?

Certain abnormalities of the genitals may in rare instances cause frigidity. Vaginal or related infections, sores, or wounds can make sexual intercourse so painful as to have this effect. After surgical or natural menopause there may be loss of desire, apathy about intercourse, and frigidity, but this appears to be the exception rather than the rule. In short, physical causes of frigidity are relatively few and uncommon. The Kinsey group was convinced that many women are constitutionally apathetic and unresponsive sexually; i.e., that way from birth. If so, "physical" factors become more important. This point of view is disputed by many psychiatrists, however, who find that such apathy frequently hides an emotional depression or other neurotic problems.

What are the psychological causes of frigidity?

These are legion. The Kinsey group found the highest incidence of frigidity in women married less than one year. Apart from age (which is probably a minor factor), the principal reasons include inexperience, embarrassment, fear, and related emotions. The inexperience of the husband is not to be ignored. Fear of pregnancy is frequent in married students or young working couples. Unconscious (neurotic) conflicts account for many cases of chronic frigidity: fear of men, fear of pregnancy, fear of death, wish for a mother rather than a husband, fantasies of the penis as a weapon, so-called "penis envy," and so on. In short, psychological factors—sometimes benign, sometimes serious—are responsible for the vast majority of cases. This, of course, includes ignorance and inexperience as psychological factors.

Is frigidity a symptom of physical and/or mental illness?

Frigidity is certainly present in many women who are physically or mentally sick, but it is the product of many factors. If a woman with tuberculosis, for example, is frigid, it is less because of the tuberculosis itself than of fear, worry, debilitation, feelings of being unattractive, and so on. In mental illnesses, frigidity is usually a by-product of emotional withdrawal, distraction, upset, and related mental states. In some neurotic illnesses, of course, frigidity is the direct result of sexual conflicts or conflicts expressing themselves in the sexual relationship.

What is the relationship between the menopause and frigidity?

There is no necessary connection. A woman who is upset, embarrassed, or depressed at the time of the menopause may be frigid for these or similar reasons. Many women, however, go through the menopause with reasonable comfort and good spirits, with no change in their enjoyment of sexual intercourse. Loss of the fear of pregnancy with the menopause and freedom from the use of contraceptives enhance the sexual pleasure of many women. (See *Menopause*)

Is there a relationship between a woman's menstrual cycle and frigidity?

There may be, but there is much individual variation. Women are likely to be easily aroused during part of the cycle and indifferent otherwise, and when indifferent they may be frigid. Many women are most responsive about midperiod when ovulation occurs, but in the case of others the phase of the cycle makes little difference in their response or lack of it. (See *Menstruation and the Sexual Cycle*)

Is there a relationship between masturbation patterns and frigidity?

The Kinsey group found, statistically, that women who masturbated prior to marriage were less likely to be frigid after marriage than those who did not. This may be because they are more responsive females to begin with and also because, in addition, they have had the experience of orgasm. Some women, however, enter marriage so fearful and guilty about their earlier masturbation that they cannot enjoy sexual intercourse. A so-called fixation on masturbation can be a symptom of unconscious sexual problems in women who are frigid for the same reasons. A frigid woman often turns to masturbation for release of sexual tensions, but masturbation continuing after marriage usually points to more pervasive neurotic problems.

Is there a basic difference between men and women in their attitudes toward intercourse that might have an effect on frigidity?

This question is debated endlessly. Men are described as active, penetrating; women as passive, receptive. The aim of man is said to be simply to discharge his sperm and thus relieve his sexual tension. For women, intercourse is simply the prelude to pregnancy and carries with it, unconsciously, all the hopes and dangers of childbirth. Men are likely to be impatient, whereas women like to be wooed, made love to, and gradually brought to a climax. According to Kinsey interviews, however, many women resent too much prolongation of the physical foreplay; once aroused, they too wish to move rapidly to a climax. Perhaps the matter is not so much of basic differences as it is of partners finding a mutual accommodation of their needs and pleasures in the total sexual relationship. The high incidence of frigidity during their first year of marriage suggests, certainly, that some "trial and error" is necessary for most couples to find themselves in their sexual relationship.

To what extent do events immediately following intercourse have an effect on the manner in which a woman will respond to later love-making?

The entire sexual relationship affects a woman's self-esteem and acceptance of herself. It is important for her to feel as attractive and as loved after intercourse as before or during. If her partner immediately falls asleep afterward, for example, or jumps up to go and wash himself, she may feel depreciated and dirty. Left feeling used, depreciated, and disappointed, a woman is likely to approach subsequent experiences in conflict, if not in anger. Ideally, the period after intercourse is one of mutual pleasure, closeness, and relaxation; of rest and then, perhaps, sleep.

Do extended courtships involving sexual relations not culminating in intercourse have an effect on a woman's response to intercourse after marriage?

The Kinsey group studied this question from the point of view of premarital petting leading to orgasm versus premarital petting that did not. They found a higher incidence of frigidity in the latter group. They assumed, again, that innately more responsive females will tend to respond to petting with orgasm and to sexual intercourse with orgasm. There are, however, other factors to consider. Girls who develop

strong controls in order to avoid intercourse prior to marriage may require some time to give up these controls after marriage. There are so many varieties in courtship patterns, however, that it is impossible to predict their later influence upon marital intercourse. The fact that the greatest incidence of frigidity is in the first year of marriage indicates that the transition from courtship to marriage is difficult for many couples, but the sexual relationship (in the narrow sense of the term) is but one of many factors. (See *Courtship and Engagement*)

Do contraceptive measures have an effect on a woman's response to intercourse?

Yes, for good or ill. If contraception abolishes conscious or unconscious fears of pregnancy, a woman may respond more freely. Another woman, however, will resent the use of contraceptives and be frigid. If a woman's greatest desire (unconsciously) is to have a child, then she will hate contraceptives even though expedience dictates their use. In addition, contraceptives are a bother and a distraction, and they may involve a guilt-ridden manipulation of the genitals. The man's reactions to contraception can disturb her, too, as can also an unspoken conflict between them about their use. If husband and wife are in full agreement, however, about their family planning, the use of contraceptives need not be an impediment to their sexual happiness.

Does sudden frigidity in a wife with a history of healthy sexual response indicate a change in her feelings about her husband?

Such a change means that she cannot enjoy sexual intercourse with her husband at that time. The trouble may be with her husband or within herself. A physical illness, worry over a sick child, fatigue from too many community activities, or intensification of any number of emotional conflicts must be considered as possible causes. Frigidity is a psychosexual problem and, as we have already seen, the possible emotional determinants are numerous. (See *Psychosexual Development in Man*)

Are there any physical characteristics, personality traits, or habits in men that lead to frigidity in women?

No, not universally. Some women respond to "cavemen"; others hate them. Man's possession of a penis infuriates some women to the point of frigidity. The penis symbolizes greater strength, greater freedom, or special privilege; for example, "it's a man's world." Thus

frigidity can be (unconsciously) designed to "castrate" and humiliate men. Some women may respond only to "clean" men; others only to "dirty" men. What it is in a man that attracts or repels a woman, and helps to determine her sexual response, is a matter of such infinite cultural and individual variation as to defy generalization.

What effect does the changing role of the modern woman have on frigidity?

The modern woman is less likely to be frigid than her predecessors, according to the Kinsey studies. "Modern woman" here means an "upper-level, educated woman" born after 1919 and, particularly, after 1929. It would appear that better education, greater freedom, increased sexual enlightenment, and the trend toward larger families—even with widespread availability of contraceptives—bespeak greater sexual enjoyment for the majority of modern women.

The picture is not, however, uniformly rosy. Increasing numbers of women seek careers. Their education leaves them with a keen sense of obligation to be something besides "mere housewives." Women's colleges occasionally shame their graduates who are not "contributing" outside the home. Severe conflicts between marriage and career, or between children and community activities plague many educated women. Such women may already be in conflict about their role as women (the feminine role) or their rightful place in the contemporary world (unconscious competition with men may be at the bottom of it) but, in any case, frigidity can be symptomatic of such conflicts.

Do some women unconsciously desire to be frigid and thus induce the condition?

Women sometimes desire frigidity because of guilt over sexuality, fear of loss of self-control, fear of pregnancy, fear of death in childbirth, or hatred of men and a wish to humiliate them. Just how this is accomplished is a complex psychosomatic process. Some women have genital anesthesia and so feel nothing. Others have severe vaginal spasms, precluding penetration by the penis. Other phenomena include lack of lubrication and the assumption of awkward or rigid postures during intercourse. Women in psychoanalytic treatment have reported eating candy, reading books, picking fights, or going to sleep during sexual intercourse.

Do some wives use frigidity as a weapon against their husbands?

Yes, women can use frigidity for this purpose or, being frigid already, exploit it. Power struggles enter into marriages, too. The unconscious desire, because of envy or competitiveness, to humiliate or "castrate" men is found in some frigid women. When frigidity is already present for other reasons, it can be used as a lever for martyrlike gratifications or for substitute pleasures—cars, trips, minks, etc. The sexual relationship mirrors the total marital relationship and one therefore has to study frigidity in its larger context.

How does frigidity in a mother affect her relationships with her children?

This, of course, depends upon the reasons for the frigidity as well as the nature of the mother's reactions to it. Helene Deutsch distinguishes between "benign" and "malignant" frigidity. The benignly frigid woman may be very motherly, and her relationships with husband and children can therefore be excellent. Malignant frigidity breeds marital conflict with uniformly adverse effects upon the children. Lack of sexual gratification can, in addition, make for a sense of frustration, irritability, and at least covert anger, breeding impatience with the children, fatigue, and cheerlessness. When the mother is resigned or even indifferent to her frigidity, the children suffer less. There is a new danger, however, namely, that she will turn to them for a closer and more emotionally charged relationship than is good for their development. In short, a mother's frigidity is probably never an asset to a family, but in the case of many warm, maternal types of women it is an inconsequential liability.

Do the problems brought about by frigidity affect other aspects of the home and family living?

The answer to this question is essentially the same as to the previous one. Frigidity itself is simply a symptom of deeper personal or marital problems, the effects of which may be hardly noticeable in the home or may be all-pervasive. We have seen that the term frigidity itself may be defined too narrowly, and that there are many satisfied women who do not experience orgasm. Even without sexual gratification, a woman can function happily as wife and mother. It is true, however, that many women who cease being frigid undertake all aspects of homemaking with greater energy, happiness, and satisfaction. Such a change derives from more than the narrow sexual response,

however; it is the product also of increased self-esteem, sense of worth, and self-acceptance as a woman. Some women, in other words, can feel confident and womanly without orgasm or other sexual gratification; others, largely because of social conditioning, cannot.

How does frigidity affect a woman in her relationships with people outside her home?

It is important always to regard frigidity as a symptom and to remember also that women react to it very differently. If the causes of frigidity include physical debility, fatigue, and ill health, a woman's outside relationships will reflect her total ill health. If frigidity makes her tense, irritable, and dissatisfied, these reactions are likely to show. When intense competitiveness with men is in the background, a woman can be brisk, brittle, and overly intellectual—not to mention aggressive, cynical, and generally hostile—in her relationships. Neurotic repression of sexuality resulting in frigidity may nevertheless cause another woman to be especially lively, vivacious, and unconsciously seductive—up to the point of serious involvement. There is also the question of a woman's attitudes toward her frigidity and these vary from acceptance to shame, shyness, and withdrawal, some of which may be apparent to others.

Are there any physical characteristics common to frigid women?

No. A frigid woman may, of course, be tense, irritable, and unhappy in her appearance, but such an appearance only indicates worry or distress of some sort. Some very tense and angry-looking women are anything but frigid.

Is there a relationship between frigidity and sterility?

There is no necessary connection. A frigid woman frequently has a large family of children. The statistical likelihood of pregnancy is, however, enhanced by good genital response occurring during the fertile period. Frigid women will, on the average therefore, be less fertile than sexually responsive women who, enjoying sexual intercourse, will experience it oftener and by their reaction improve the chances of conception. (See *Sterility*)

Is the sex drive weaker in frigid women?

This is a moot question. The Kinsey group was convinced that some women are constitutionally more apathetic and less responsive

than others. Where ill health or similar factors influence libido (sex drive), they may simultaneously contribute to frigidity. In much emotionally induced frigidity, however, there is no basic or innate weakness of the sex drive, but rather an inhibition or distortion of it due to shame, guilt, or various neurotic conflicts, usually, if not universally, centering about unconscious anxiety.

Are there any psychological characteristics that are common to frigid women?

No. It is impossible to diagnose a frigid woman by her outward "personality," and there are no psychological patterns common to all frigid women.

How do parents' attitudes toward sex and sex education affect the possibility of frigidity or impotence in their children?

Parents who are prudish, inhibited, or neurotic about sexual matters will tend to transmit these attitudes to their children, not by heredity, but rather by emotional and other attitudes (often very subtly conveyed) throughout the children's formative years. The parents, however, are never the only influences and cannot always be held accountable. The growing child makes his own observations of animals and gets more or less garbled information from other sources. In addition, he has his own, often vivid, imagination and his fantasy life. The influence of the parents is generally of the highest importance, but one cannot ignore nursemaids, baby-sitters, and other factors in the child's total environment. (See *Sex Education*)

What other family situations might lead to frigidity or impotence in children after they grow up?

There are many, and most of them represent misinterpretations (in fantasy) of childhood experiences. Very young children seeing or hearing their parents having sexual intercourse (primal scene), for example, often interpret the event as a struggle or fight—something very much to be feared. If associated with their own excitement or early masturbation, it may lay the foundation for later anxieties sufficient to produce frigidity or impotence. Childhood masturbation followed by a tonsillectomy, a fall down stairs, or a separation from the parents can be interpreted—despite reassurance—as a punishment for sexuality and thereby contribute to later sexual problems. Usually there is a

multiplicity of causative factors, and not all of them can be anticipated or dealt with by even the most enlightened parents.

What might be some disturbing physical effects of frigidity?

Physical consequences of frigidity depend upon emotional reactions to sexual frustration and upon vaginal (and nearby) reactions to undischarged sexual tension. The former range from nil (or inconsequential) to psychosomatic expressions of rage, shame, grief, or other powerful feelings. From this point of view, frigidity could be one factor in increased blood pressure, dyspepsia, chronic fatigue, and various allergies. Vaginal and pelvic reactions are probably due mostly to abnormal changes in the blood supply resulting from unrelieved sexual excitement. In any event, frigidity is sometimes held responsible for cases of vaginal discharge (leukorrhea), genital infections (nonvenereal), and other pelvic conditions.

Is there a relationship between frigidity and promiscuity?

Yes, but no regular or inevitable relationship. It has been claimed that most prostitutes are frigid. Some hate men, and in their prostitution and frigidity degrade and humiliate them while (superficially) gratifying them. Others may become frigid out of shame, disgust, fear of infection, and other circumstances of their sexual activities. Some frigid women find that they are not frigid with extramarital partners, and thereby become unfaithful, if not promiscuous. Still other women are both frigid and promiscuous on the basis of unconscious homosexual tendencies or fears; they "deny" their homosexuality by the outward appearance of unusual heterosexuality. When a frigid woman is unfaithful or promiscuous, it may be because her husband is inept or otherwise primarily responsible for her frigidity or it may be because her own neurotic problems are projected onto the husband or other partners, causing an unending search for the man who can satisfy her.

Is it possible for a frigid woman to fall in love?

Yes, indeed. Much depends, of course, on one's definition of love, but by any definition there are aspects and forms of love that have little to do with sexual gratification. Helene Deutsch distinguishes "malicious" and "benevolent" frigidity and applies the latter term to passive, tender, motherly women whose deepest gratification lies in providing

sexual satisfaction for their partners. Many men long for the all-giving earth-mother type of marital partner, and at least a few women fulfill such dreams without orgastic sexual satisfaction for themselves.

Are sexually satisfied women disturbed by the fear of becoming frigid?

They are not likely to be. If they are, some sexual conflict is present even though not expressed in frigidity. A woman who feels unconsciously guilty about sexual enjoyment might, for example, achieve ecstatic sexual gratification, and then worry about frigidity the next time. The chances are that this would be a form of neurotic punishment for having had so much sexual fun, a "bribe" to the superego (conscience) as Franz Alexander once described it.

Can a frigid woman express her frustration or repressed sexual desires in other ways?

This is really two questions. *Sexual frustration* implies a conscious awareness of unrelieved sexual desire or undischarged sexual tension. A woman may deal with this by masturbation, hot baths, "working it off," or more or less patiently letting it wear off. She may fly into a rage, pick a fight, or go into the kitchen and gorge herself with food. *Repressed sexual desires* are, by definition, unconscious; i.e., the individual does not know about them. These may express themselves in restlessness, irritability, overeating, orgasms during sleep, various "driven" social or recreational activities, or neurotic symptoms. It is important, again, to remember that a woman may be reacting to the underlying problems that cause the frigidity, or she may be reacting to the frigidity itself, regardless of the causes; and, also, that what she does may be consciously planned or unconsciously motivated.

Is it advisable for a frigid woman to marry in the hope that marriage will solve her problem?

Probably not. If a woman knows that she is frigid, the presumption is that she has already had sufficient sexual experience, and marriage is not likely to change matters. Obviously a woman should not jump to the conclusion that she is frigid on the basis of limited experience or on the basis of a sexual life attempted under adverse and insecure circumstances. Such a course is bad, also, because it focuses upon a symptom rather than upon whatever may be causing it. One must really have a thorough understanding of the probable reasons for

frigidity in a given case before forming an opinion as to whether it will be a problem in marriage or not.

What steps can a frigid woman take to help herself before enlisting professional help?

If a frigid woman can free herself from feelings that her condition is a stigma and deal with it as a problem to be solved, she will have taken a highly important first step. Frank discussion with her husband, in this frame of mind, is equally important. Does sexual intercourse occur under optimal conditions of privacy, tranquility, and repose? Can hitherto unvoiced needs, wishes, or minor irritations be tactfully revealed? Even slight changes in the time, place, and circumstances or in the techniques of lovemaking can sometimes spell the difference. Giving up rigid attitudes about what is "normal" and modifying perfectionistic expectations about simultaneous orgasm—trying too hard—can sometimes effect a more relaxed attitude and pave the way to greater satisfaction. Marriage manuals can offer useful suggestions, but even they, sometimes, must be taken with a grain of salt if they emphasize idealistic goals. Taking stock and talking things over will sometimes obviate the need for professional help; if not, seeking professional help is the next step in trying to solve the problem.

Can a husband help his wife in overcoming frigidity?

Sometimes he can do everything; sometimes nothing. Mutual sympathy and understanding may do wonders. Better understanding of his wife's needs and responses can make the husband a more skillful lover. Whatever improves the emotional rapport between husband and wife tends to improve their sexual relationship. The frigid woman should not expect miracles from self-help or assume that the husband's skill or technique is the determining factor. Nevertheless, given time, patience, and a mutually sympathetic experimental approach to all aspects of lovemaking and sexual intercourse, many couples can overcome frigidity or impotence or both.

Can frigidity be cured by treatment?

Many cases of frigidity have been cured by treatment. Remember, however, that frigidity is not a disease; it is a symptom. Whether treatment will be helpful, and what kind of treatment offers the best chance, depend upon a diagnosis of the underlying causes. The nature of the causes will determine whether treatment should be medical, surgical,

or psychological. If the latter, treatment may consist of everything from simple information about the "facts of life" to psychoanalysis for unconscious emotional conflicts about sex.

Is sexual anesthesia curable?

Sexual anesthesia is really a kind of frigidity, but it means a total lack of sensation in and around the vagina. The possibility of cure, again, depends upon the underlying causes. In certain injuries to, or diseases of, the spinal cord or of nerves to and from the genitals, there is no cure. Such conditions, however, are relatively rare. Sexual anesthesia resulting from hysteria or some other neurotic problem may yield to appropriate psychological treatment.

How is physically caused frigidity treated?

The first step, of course, is the diagnosis: What is the physical condition that causes or contributes to frigidity? It may be as simple as a tough hymen (maidenhead) that needs a simple surgical procedure. A painful "blister" or cyst of the urethra (bladder outlet) or elsewhere at the vaginal opening might be the problem to be dealt with. Curing one of any number of chronic tiring and debilitating conditions, may be the answer; i.e., improvement of general health and well-being. Endocrine (hormone) treatment helps in carefully selected cases.

If a woman's frigidity is incurable, can she have a happy marriage?

Yes. Sexual happiness, however desirable, is not everything. There are many kinds of happy marriages ranging from those where there is renunciation of the pleasures of sex to those where, by mutual agreement, sexual gratification is found outside of marriage. Happiness is a matter of numerous satisfactions and is to some extent relative to one's expectations. Sexual gratification, particularly for the wife, plays a relatively minor role in many marriages. In any case, for many couples a wife's frigidity is no great obstacle to a happy marriage.

What are aphrodisiacs? Are they successful in treating frigidity?

Anything that stimulates or intensifies sexual desire is an aphrodisiac. This can include anything from a seductive or erotic dance to the subtle lines of a French pastry. Generally, however, the term applies to drugs (including alcohol) that arouse or release the passions. A glass of wine may be an aphrodisiac in the sense that it relaxes, soothes,

promotes a sense of well-being, and fosters intimate conversation. But sexual desire is not enough, and, for this reason, what enhances desire may have no effect upon frigidity. There are two important dangers in the use of aphrodisiacs even if they are apparently helpful: (1) they deal with a symptom, and not with the underlying causes; and (2) they may lead to the use of increasing amounts and thus become habit forming or involve the risks of overdosage. Except for the glass of wine that goes with a good meal, the use of drugs or aphrodisiacs is not to be recommended except under medical supervision.

Are external ointments or mechanical aids helpful in treating frigidity?

The vagina is normally moist and lubricated during sexual intercourse. When this is not the case, the use of artificial jellies or ointments can prevent a difficult, even painful experience and may, in some cases, overcome frigidity. Apart from preventing dryness, such agents are probably of little value. Some mechanical aids—such as "ticklers" worn on the penis—are used, but their effectiveness is more a matter of folklore than of scientific knowledge. They, too, have the disadvantage of "treating" the symptom rather than the more basic problems. A further disadvantage of any symptomatic treatment is that it postpones the day of adequate diagnosis and definitive treatment.

Are tranquilizers or other drugs useful in treating frigidity?

In general the answer is, "No." It is true that a tranquilizer or similar drug might counteract tension or other "nervousness" sufficiently to overcome frigidity. The dangers, however, are the same as with alcohol: (1) possible overdose, (2) possible habituation, and (3) putting off the day of thorough diagnosis and more specific treatment. If prescribed and regulated by a physician, they may be worth a try; otherwise, it is better to avoid them.

Are hormones successful in the treatment of frigidity?

The causes of frigidity are almost always psychological, and hormones are therefore seldom useful. Where there is a proved endocrine deficiency, hormone therapy may help. If so, the effect is not direct, but rather due to restoration of the normal balance of highly complex physiological processes affecting ovarian activity and the whole female sexual cycle. Hormone therapy has its dangers and should be used, if

at all, only after a total physical and psychological evaluation of the problem. (See *Hormones and Behavior*)

What has been the success of psychiatry and psychoanalysis in the treatment of frigidity?

Very good, in selected cases. Psychiatrists, including psychoanalysts, emphasize the importance of careful diagnosis. Where the principal problems are psychological, psychiatric treatment may be successful. If unconscious neurotic conflicts are involved, psychoanalysis may be the treatment of choice. No approach can guarantee favorable results, but the selection of the treatment method to be tried must follow careful evaluation of all possible reasons for the symptom of frigidity. One must add a note of caution, however: treatment of frigidity can be disappointing if the standard of cure is intense vaginal orgasm. A more realistic and attainable goal is increased marital happiness and gratification from sexual intercourse.

Is it necessary for the husband of a frigid woman to undergo therapy?

Yes, even though the therapy is limited to one interview. Discussion with the husband is an essential part of the total evaluation. His feelings about the problem may be part of it and, in any case, his cooperation is imperative. Sometimes, the husband is largely responsible for his wife's frigidity. In other cases he consciously or unconsciously welcomes it. Treatment of the husband may therefore range from a single consultation to psychoanalysis.

Is hypnosis successful in the treatment of frigidity?

Yes. Hypnosis is sometimes successful in alleviating the tensions, fears, or feelings of inadequacy that contribute to frigidity. There are serious limitations to hypnosis, however. There is always some danger in removing a symptom without treating the underlying causes. If frigidity expresses deep-seated emotional problems, the effects of hypnosis will be short-lived or will lead to the appearance of some other symptom to replace the frigidity. For adequate safeguards, hypnosis should be used, if at all, only under experienced medical supervision. (See *Hypnosis*)

Can a woman who has been cured of frigidity experience a recurrence of the problem?

Yes. Any woman may be frigid under conditions of internal or external stress, and a woman who has been successfully treated for

frigidity is no exception. If frigidity becomes permanent again after a cure, she will have to look for other factors than the ones dealt with in her therapy. A new evaluation is indicated, and perhaps more treatment.

What can social, religious, and educational agencies do to prevent the development of attitudes and fears that may lead to frigidity?

Community programs that provide or promote sound, wholesome sex education contribute to the prevention of frigidity. Sex education begins, of course, in the home, and the enlightenment of young people through college courses in marriage and the home or of young parents through family life education will help the oncoming generation. Premarital counseling by clergymen, physicians, planned parenthood clinics, or other marriage counseling services will achieve a double purpose: (1) the sexual instruction of the young couple themselves; and (2) the promotion of a healthier home atmosphere for the children when they come along. Such services are not universally available, of course, nor are all programs equally sound. Health and welfare agencies in all communities can always review their programs with an eye to unmet needs, including the extension or improvement of existing services.

Based on current research and studies, what can be predicted about the prevalence and treatment of frigidity in the future?

Because most cases of frigidity are psychologically determined, new solutions will probably come from the mental health field. Prevention, through better child rearing and premarital counseling, will almost certainly be more effective than treatment of individuals already burdened with the problem. There is no present indication of dramatic developments in this field. The most hopeful signs are those of increasing recognition of frigidity as a medical (predominately psychological) problem, and of more widespread programs of prevention through family life and child rearing education.

GENIUS

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What is genius?

Genius is extraordinary personal force, shown in either intellect or character, and commonly in both. Men and women of genius are creators of new forms, and sometimes incidentally destroyers of old forms, in all the enormous variety of ways in which human will and intelligence may manifest themselves: in all the sciences and arts, in mathematics and philosophy, in social institutions, in politics and religion, in exploration and invention, in military action and in commerce. There are as many varieties of genius as there are distinctive human activities in which extraordinary personal force may find expression.

When is genius recognized?

The signs of potential genius usually precede the accomplishments by which the genius finally attains general recognition. Genius often shows itself very early in life, sometimes as early as the age of four or five. This is particularly true in the intellectual sphere—in music, language, mathematics, and science. There are exceptions to this rule, of course, but often the cases which are claimed as notable exceptions, such as the "dumb ox" legend about Thomas Aquinas and stories of Albert Einstein's dullness in school, prove upon close examination to be fictions.

Can genius be measured or tested?

Genius cannot be "measured" or "tested" in any precise fashion. Relative strength of intellect can indeed be estimated with a practical degree of accuracy by intelligence tests, and there are some personality tests which give promise of useful measurement of traits associated with genius. Genius itself, however, is so diverse in its ways of expression, and so individually distinctive, that the term "measurement," in the sense in which it is generally used in psychology, does not seem applicable.

What is the meaning of "a genius I.Q."?

In the early days of the mental testing movement, shortly after World War I, Lewis M. Terman used the term "potential genius" for any child whose estimated intelligence was at a level reached by only one child in 200. The intelligence quotient, or I.Q. as it came to be known popularly, is a ratio of estimated mental age to actual chronological age. An I.Q. of 140 is approximately the level necessary by Terman's criterion for the designation, "potential genius." Terman's criterion has been disputed on the grounds that he set too low a standard and that many characteristics besides high intelligence are necessary if a person is to be called a genius.

What are some of the signs of high intelligence that are used in estimating an I.Q.?

These will differ to some extent at different ages, of course, since an I.Q. of 140, e.g., will be earned by a five-year-old child who shows the mental accomplishments typical of a seven-year-old, and by a ten-year-old child who shows the accomplishments typical of a fourteen-year-old, and so on. Nevertheless, there is a consistency of intellectual factors at all ages. The most important seem to be these: extensiveness of vocabulary and information (verbal comprehension and acquisition), facility in reasoning and problem-solving, numerical ability, the ability to recognize and manipulate simple geometrical forms in space and accuracy, and fluency of perception.

Would a genius be expected to score high on all factors of intellect?

Persons of exceptionally high intelligence usually are high on all factors; however, there are many instances of geniuses who are virtually incompetent in some areas of intellectual functioning. There are special aptitudes which seem to develop almost independently of other factors, such as musical aptitude, ability at drawing and painting, and perhaps mathematical aptitude to some extent.

What is an "idiot savant"?

Idiot savant is a term applied to the supposed case of an individual of very low general intelligence (idiot or imbecile level, I.Q. below 50) who nevertheless shows superior ability in a single intellectual function, such as arithmetical reasoning, memory for words or sounds, mechanical aptitude, talent in drawing, and the like. Many such cases were reported

in the first two decades of the mental testing movement in this century, particularly in France and in England, but there is considerable reason to doubt that the reports were accurate in appraising the general intellectual level as that of idiocy or imbecility.

It is more likely that some persons who are suffering from congenital mental defects—caused either by birth injury or some irregularity of fetal development or heredity—or who are victims of childhood schizophrenia, but in whom the basic quality of intellectual functioning is otherwise normal or superior, are reported as idiots with a mysterious specific ability.

Can genius be inherited?

Geniuses occur in the same family stock much more frequently than could be expected if there were not some hereditary transmission of characteristics which make for unusual force of intellect or personality. In 1869, a brilliant study of the hereditary transmission of genius made by the famous eugenicist and psychologist, Sir Francis Galton, produced clear statistical evidence that genius runs in families. Havelock Ellis added much confirmatory evidence and offered some theories as to possible biological mechanisms in his *British Men of Genius*, based upon the biographies of nearly one thousand geniuses. Lewis Terman's evidence in *Genetic Studies of Genius* likewise supported the general thesis that genius is inherited.

The consensus of all responsible investigators is that genius, in the sense of *potential* extraordinary achievement and force of intellect and personality, is a product of a person's constitutional makeup. However, what deserves to be emphasized here is that the hereditary mechanism is by no means a simple and unfailing one, and that even at the genetic level, to say nothing of what happens as life develops, there are multiple chance factors which in the main are more important than transmission of potential through family lines. To put this another way, genius most frequently arises in family lines whose history indicates little more than ordinary endowment, even though it is also true that if one genius turns up in a given stock, another genius is much more likely to appear there than is a first genius likely to appear in a family without a history of genius.

Can genius be produced by environment?

It seems probable that there are more favorable and less favorable environments for the development of genius, if "environment" is used

in a broad sense of the word. Athens from about 500 B.C. to about 200 B.C., and Florence in the fourteenth and fifteenth centuries A.D., are noteworthy instances of the flowering of genius in geographical locales quite limited in space but offering extraordinary freedom for personal expression. Often, at least in retrospect, it seems as if "the time was ripe" for the man of genius to arise, whether in the affairs of states or in times of crises in science or religion. It is fair to say that the potential for genius needs to meet a potential receptive or ripening quality in the culture. The best guess is that many men and women of potential genius never find the right time and place to develop and use their talents.

Why does it seem that genius occurs more frequently in males than in females? Could this have anything to do with environment?

There are at least one hundred male geniuses to every female genius, on the whole, although the ratio will vary according to field of endeavor. In the fields of mathematics and music, for example, women almost never attain fame as inventors or composers. Female geniuses in literature appear somewhat more frequently, but are still insignificant in number.

No satisfactory account of this difference in numbers of male and female geniuses has as yet been given, although social environment would seem at first glance to be an important consideration. Women, traditionally, have been assigned an inferior social role, with cultural expectations linked to childbearing and homemaking and consequent limitation of opportunity for expression outside that role. Both direct and indirect biological factors, in turn, determine social expectations. Women are smaller, softer, less capable of the extremes of exertion, and are destined in the prime of life to spend much time in the creating and rearing of offspring. They are, for the most part, more conservative than men, and less aggressive.

In scores on intelligence tests, men and women are equal on the average; the important difference appears to be in the cultural and biological situations in which the given intelligence operates. In nations such as the U.S.S.R.—where an unprecedented number of women are doing jobs traditionally assigned to men—it remains to be seen whether a greater proportion of women geniuses will appear.

How does the percentage of geniuses in the population of the United States compare with that of other countries?

No exact comparison can be made because there is no sure basis for classifying a person as genius or not genius and because of the his-

torical circumstances surrounding the comparatively recent settling of the United States. The rate of increase of our population from 1750 to 1950 makes comparison with European nations almost impossible. However, the "national genius" of the United States undoubtedly must be called extraordinarily forceful, in view of our ascendancy in economic and political and military power, and our leadership in industrial organization and technological innovation.

The vexing question is whether the national environment is actually favorable or unfavorable to the emergence of genius in persons born in the United States, or of persons of the third or fourth generation here. Many of the undoubted geniuses who were American citizens were immigrants or were born here of immigrant parents. However, in appraising this fact, it must be remembered that only seven or eight generations have passed since the early colonies began being more American than European.

Has the community attitude toward the genius been changing?

Geniuses tend either to be ignored or met with hostility, in the United States as elsewhere. This probably arises from the general tendency of humanity to view anything exceptional as worthy of suspicion, because it is likely to go counter to our familiar ways. Geniuses are usually strong willed, independent, unconventional, and self-assertive, and are often seen as unruly, egocentric, immoral, irreverent, impious, heretical, and destructive, which indeed they may be.

Is there any connection between genius and mental disorder?

It has long been a popular conception of genius that "it is to madness near allied"; hence the term "mad genius," and the stereotyped picture of the genius as being badly in need of a haircut and bath, given to extremes of emotion and impulsive action, wild-eyed, out of touch with common human feeling, and so on. Actually, most stereotypes have some foundation in fact, and this one is no exception. However, there are a multitude of geniuses who do not fit this description at all, and even where the description does fit, the interpretation that genius is close to madness is most often incorrect.

Havelock Ellis, in his study of British men of genius, showed that the percentage of geniuses who have psychoses is very close to that of the general population. Geniuses are neither more nor less inclined than the average man to fall victim to serious mental illness requiring hospitalization. In the Terman studies, persons of higher intelligence even among the already highly select sample of "potential geniuses," proved

to be somewhat more stable and psychologically healthy than the less intelligent. Nevertheless, there is ample anecdotal evidence to suggest that geniuses do behave very oddly in comparison with most other people, and that they are more given to extreme changes in their emotional states. Geniuses, however, retain a strong sense of reality even in the midst of their unusual feelings and behavior, and they seem to have more capacity to "right themselves" after periods of imbalance. Moreover, those very periods of imbalance are themselves essential for novel, divergent thinking that may turn science or art or public affairs in a new direction.

The imbalance of the genius, as distinct from that of the mentally ill, seems in retrospect to have been almost purposeful, or at least to have been necessary as a stage of preparation for arriving at an unusual new solution more comprehensive than the popular one.

What effect can education have upon the potential genius?

This is a difficult question to answer, because one of the traits of the genius is that he tends, to a remarkable extent, to be self-educating. The definition of genius as "99 per cent perspiration and one per cent inspiration" is apt, even though it sacrifices accuracy to make a point. The point is that the genius is usually a very hard worker, highly self-disciplined in the matters which he considers important, and possessed of a strong drive to acquire mastery of relevant technique in order that his larger goals may come within his grasp.

It is probable, however, that much talent has been lost to society because of inadequacies in education, and it is likely also that the wrong sort of education can prove stultifying. If originality is punished in our school system, it will either die, hide itself, or turn to delinquency. Nature produces the potential for genius; what happens afterward is up to the individual and to society.

THE GIFTED CHILD

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What is a gifted child?

A gifted child is one who is capable of remarkable performance in some socially approved endeavor. To some people, the gifted child is one with a high intelligence quotient (I.Q.), but a child may be gifted because of outstanding ability in athletics, leadership, art, music, science, mathematics, mechanics, or any other area. A recent development has been the broadening of our concept of intellectual giftedness to include mental abilities other than those tested by traditional measures of intelligence or scholastic ability. An outstanding example is creative thinking ability.

Are there classifications of giftedness in children?

It is possible to think of giftedness in terms of both the way in which, and the degree to which, one is gifted. Even in the area of intellectual giftedness, one may exhibit outstanding ability in such diverse ways as remembering, logical reasoning, thinking of original ideas, making estimates or judgments, etc. Degree of giftedness is usually determined on some comparative basis, such as the upper one-tenth of 1 per cent, the upper 1 per cent, or the upper 10 per cent of some population. Whatever classifications are made, however, they have meaning only insofar as they relate to behavior recognized as valuable by society.

May a child be gifted in one area of ability and not be gifted in other areas?

Yes. It is quite erroneous to think that a gifted child must be gifted or specially endowed in all areas of performance. It is true that there is a small but statistically significant relationship among various kinds of abilities, but the relationship is far from perfect. For example, if we should designate as gifted all children who rank in the upper 20 per cent on a test of intelligence, we would miss about 70 per cent of those who rank in the upper 20 per cent on tests of the

creative thinking abilities (ideational fluency, originality, flexibility, elaboration, etc.). There is a tendency, however, for those who are exceptionally high on tests of creative thinking to be reasonably high on tests of intelligence and vice versa, at least when wide ranges of ability are considered.

Does the professional psychologist differentiate between the gifted child, the talented child, the genius child, the creative child?

The terms are overlapping, but some professional psychologists attempt to make such distinctions and prefer to be precise in their use of the labels "gifted," "talented," "genius," and "creative." The term genius has traditionally been reserved to apply to extraordinary or rare levels of giftedness, talentedness, or creativity. It is now becoming fairly common to distinguish between children with a high I.Q. and children with high creative thinking abilities. For example, a child with a high I.Q. may or may not be able to produce original ideas of a high order, even though he is good at memorizing, logical reasoning, and recognizing the correct answer. He might be considered gifted or talented but not creative.

What methods are used to determine whether or not a child is gifted? Who is qualified to determine this? Where might tests be obtained? Is there a charge?

The gifted child may be identified by means of tests, observations of behavior, or by his productions or achievements. "Determination of giftedness" is usually by means of some battery of tests. Tests of intelligence (I.Q.) and scholastic aptitude are perhaps most commonly used. There is a great variety of these tests, ranging from the individually administered ones, such as the Stanford-Binet and the Wechsler-Bellevue Intelligence Scale for children (W.I.S.C.), to group tests, such as the Kuhlmann-Anderson Intelligence Test, the Otis Quick-Scoring Mental Ability Test, and the California Test of Mental Maturity to various nonverbal tests, such as the Goodenough Draw-a-Person Test. Achievement tests, measures of special abilities (music, art, mechanical, clerical, etc.), and tests for assessing the creative thinking abilities may also be used.

Many schools and school systems routinely administer—at various intervals—group tests of intelligence and achievement. Usually these are administered by classroom teachers or school psychologists at no additional expense to the parents. Individually administered tests are

usually given by the school psychologist, a psychoeducational clinic, a mental hygiene clinic, or some similar agency. Such individuals and agencies may also administer the various measures of special ability, since their intelligent use requires special training and experience in psychology or educational psychology. If the service is provided by the school system, there is usually no charge to the parents. A charge, however, is made by most agencies outside the school system.

Thus far, tests of creative thinking used in identifying the creative child have been used only in research and experimental programs. It is to be expected, however, that these tests will soon be available in much the same way as intelligence tests are now available. (See *Intelligence Testing*)

Does it naturally follow that a child with a high I.Q. will be a gifted child?

If giftedness is defined in terms of performance on standardized tests of intelligence, then a child with a high I.Q. is by definition a gifted child. If we accept the concept that giftedness is manifested in remarkable behavior which is socially beneficial, it does not necessarily follow that the high I.Q. child is also a gifted child and the child with a low I.Q. is not. There are some indications, however, that there may be thresholds or minimal levels of intelligence (I.Q.) necessary for behavior which could be labeled gifted, talented, or creative. Perhaps an I.Q. of around 120 is requisite for talented or creative performance in most of the professions.

Is there a greater incidence of gifted children in one of the sexes? In certain national groups? Economic groups? Religious groups? Rural vs. metropolitan groups?

Insofar as achievement is intimately related to opportunity, certain differences among various national, economic, religious, and rural-urban groups are bound to occur in any society. In American culture, boys and girls are rewarded differently; their curiosity and exploratory needs are treated differently; and certain areas of thinking and achievement are tabooed for one sex but not for the other. As a result, few women show giftedness in invention, scientific discovery, musical composition, art, architecture, and the like. Whether men are innately superior to women in these areas is seriously doubted.

How many gifted children are there in the United States today?

The number of gifted children in the United States is necessarily dependent upon one's definition of giftedness. Since this is such a complex matter, as has already been shown, it does not seem possible to estimate the number of gifted children in the United States.

Is the number of gifted children in the United States changing? If so, why?

If the premise can be accepted that giftedness can be enhanced by means of educational experiences, a case might be made for the proposition that a larger proportion of American children today can be classified as gifted than could have been so identified ten or twenty years ago. Also, as we expand our concept of giftedness to include other types of abilities than those measured by intelligence tests, we increase thereby the number of children who might be recognized as gifted in some way.

Does the proportion of gifted children in the United States differ from that of other countries?

It is not now possible to determine whether the proportion of gifted children in the United States is different from that of other countries. Although there are problems of language differences, measurement, sampling, and the like, a number of promising comparative studies are now in progress at such institutions as the University of Minnesota, Michigan State University, Pennsylvania State University, etc. Since different cultures reward and punish different kinds of performance, educational opportunity, and the like, it is to be anticipated that there will be differences in the proportions of various kinds of gifted children.

What is the present status of the gifted child in this country?

The status of the gifted child is dependent upon the nature or composition of his community and what is honored there. There has been during the past decade more and more recognition of the importance of developing the various talents of our youth. More and more opportunities are being provided for the cultivation of various kinds of talents, especially intellectual talents. In general, however, the gifted child is by definition "different" and as such suffers the estrangement and discomfort which this entails. Response to the gifted child's

being different may be positive as well as negative. Even this might be quite overwhelming to the child. Comparatively speaking, however, special provisions for the intellectually gifted do not approach those for the mentally retarded and various other types of handicapped groups.

Is the gifted child generally aware of his difference?

This is a complex question and there is inadequate research information to answer it. In general, however, the gifted child is keenly aware of his exceptionality, and this may lead him to hide his unusual talents or to become isolated from his peers, teachers, and parents. He does not always place a positive evaluation on his giftedness and may even despise it because it makes him different. Most gifted children are not looking for special or privileged treatment; like other children, they seek understanding.

What creates the gifted child?

Physiological, psychological, environmental, and hereditary forces all interact to create the gifted child. Giftedness, talentedness, creativity, and genius are all inherited *only* to the extent that sense organs, a nervous system, etc., are inherited, but the extent and direction of their development will depend largely upon how the society treats his curiosity and exploratory needs, status and love needs, even his safety and physiological needs.

Are there physical characteristics that identify the gifted child?

There seems to be a positive, though far from perfect, correlation between physical health and attractiveness and giftedness, especially intellectual giftedness. At the same time, however, some gifted children are exceptionally unattractive, physically handicapped, or retarded in their physical development.

Are there psychological characteristics that identify the gifted child?

In order to draw up any list of psychological characteristics of the gifted child, it would be necessary to specify the type of giftedness in question. The *creative* child is able to see relationships readily. He has a vivid imagination, is intellectually curious, looks for novel solutions, likes to play around with materials and ideas, is persistent, is enthusiastic, has strong needs to express himself, likes complexity, is

willing to take risks, cultivates his intuitive abilities, is relatively in-dependent in his thinking, is flexible and adaptable, has a venturesome spirit, is challenged by problems, reacts spontaneously and is open to his experiences, finds the unknown attractive, enjoys making guesses or hypotheses, is sensitive to change, and becomes deeply engrossed in activities which interest and challenge him.

Are there mental disorders that affect the gifted child in particular?

In general, the gifted child is blessed with better mental health than other children. Since gifted children are by definition "different" and being different is frequently equated with mental illness or de-linquency, gifted children are popularly regarded as maladjusted. This is especially true of the highly creative child, since he is usually char-acterized by his originality. If he suppresses his creativity, his self-con-cept is likely to be uncertain and unrealistic. Serious learning dis-abilities, delinquency, neurotic conflict, even psychosis may result from prolonged, enforced repression of his creativity. If he maintains his creativity, however, he may feel isolated and psychologically estranged. In any case, such children may need guidance.

Are there sociological characteristics that identify the gifted child?

As in the case of psychological characteristics, the sociological characteristics of gifted children depend upon the kind of giftedness under consideration. Since different social groups honor different kinds of achievement, different kinds of giftedness will be cultivated in them. Also, our society supports giftedness in certain groups along certain lines and not along others. For example, it has been possible for Negroes to achieve eminence in athletics. Thus, it is not strange that in a study of third grade Negro boys large numbers of them aspire to become professional athletes and strive to develop the talents which will enable them to achieve such a goal.

How early can the gifted be identified?

We do not yet know how early the gifted can be identified. Since giftedness is determined in part by the way the environment treats the child, the problem is a complex one. It is generally thought, however, that intellectual giftedness (in terms of conventional intelligence tests) can be identified with a reasonable degree of reliability at about the ages of five or six. Tests of the creative thinking abilities do not show

a high degree of stability until about the ages of nine or ten. It is apparent, however, that the instability before this period is due at least in a large measure to the ways in which creative needs are treated by the home and school. In the case of true genius, of course, identification may come earlier; Mozart's musical genius was observable at the age of three.

Is it possible for the gifted child to go unrecognized?

There is a very good chance that a large number of gifted children are unrecognized and will continue to go unrecognized. Much depends upon the values of the community or the culture. Many gifted children will conceal their giftedness deliberately in order to make their social adjustment easier.

What effect can a gifted child have on his family?

The gifted child may be a disturbing influence, a source of embarrassment, or a source of joy and pride to his family. It depends upon the nature of his talents and the values of his family and the society.

Are there special problems in rearing a gifted child with less gifted brothers and sisters?

Usually, there are special problems in rearing a gifted child with less gifted brothers and sisters. Depending upon the values of the family and of the society, the less gifted will suffer by comparison and retaliate, or the gifted child may suffer by comparison with them in some other ways. If all are accepted and valued as unique individuals, however, there need not be special problems. Parents, especially if they are not as well endowed as the child, must make an effort to understand the problems which their gifted youngster encounters as a consequence of his exceptionality.

What effect does the family environment have on the gifted child?

When the values and attitudes of the family are favorable in regard to the particular talents of the gifted child, he can become more effective as a contributing member, both of the family and of the community. He is thereby freed to become himself and to realize his potentialities. When his talents are unappreciated or derogated, his problems of adjustment become much more severe and the likelihood of his making worthwhile contributions to society is greatly reduced.

Do prejudices exist in the community against the gifted child? What effect might these have on the child?

Prejudices in communities against gifted children are diverse, complex, and powerful. One of the most powerful prejudices is against his being "different." Communities differ greatly, however, in the degree to which they tolerate any type of divergency. Some communities treat some types of divergency more severely than they treat others. This includes divergency in terms of giftedness, as well as in terms of deficiencies. There are also powerful pressures in most communities for boys and girls to behave in certain expected ways. Certain areas of achievement, even thinking, are sometimes blocked to one because of his sex. A community may also have prejudices against activities which have to do with fantasy, using one's hands, or speculating philosophically. The effect of the prejudice, whatever its nature, is to cause the individual who is the object of the prejudice to defend himself. In the case of the gifted child, the despised talent may be hidden from view, modified or adapted to be less offensive, consciously rejected, or displayed in spite of the sanctions of the community. All such devices are of course unsatisfactory and lead to unnecessary sacrifices of talent.

Must a gifted child live a different life from other children?

In some respects, the gifted child's exceptionality will always set him apart from others. This does not mean, however, that he must be maladjusted or unhappy. Wherever or whenever there is genuine respect for differences, his talents can be accepted as valuable. It is a legitimate aim of education that the gifted child's life should be different. If the gifted individual accepts the responsibility for the stewardship of his talents, he will live a life different from others. This does not mean that he must be haughty or arrogant, or lose touch with the lives of his peers. In fact, he may also be gifted in his ability to empathize more fully with others.

Is it possible for the I.Q. of the gifted child to change?

Because we are able to measure the I.Q., we know that it is possible for it to change in time, whether the child is gifted or not. The I.Q. will also vary, depending upon the kind of test used to assess it, since no two intelligence tests require precisely the same kinds of abilities. If the I.Q. of a gifted child drops markedly, it may be regarded as a possible sign that something is going wrong with his adjustment or development.

Are most schools able to deal effectively with the gifted child?

Although in recent years there have been many promising developments and improved practices in the handling of gifted children, most schools are unable to deal very effectively with gifted children. College and university courses on giftedness, research on various aspects of giftedness, and special programs for gifted children have multiplied. We still need to know far more than we do about what conditions are most favorable for the development of giftedness.

Are there special schools or training designed specifically for the gifted child?

Although there are a few special schools designed specifically for the gifted child, provisions more commonly take the form of special classes, differentiated curricula, enrichment centers, and special courses. Porter Sargent's *The Gifted: Educational Resources* provides a directory of eight hundred such programs and schools.

What agencies, institutions, or school programs in the community are specifically concerned with the problems of training the gifted child and his family?

Many communities have organized groups—consisting of parents, educators, and other professionals—which attempt to develop community resources for gifted children. The National Association for Gifted Children has chapters in many communities. Some of these organized groups have been effective in stimulating programs by schools, industry, and business, and in obtaining legislative provisions for research and experimental programs. Science and Arts Camps, Inc. is a relatively new organization devoted to the development of camp programs for gifted children.

What are the qualifications of professionals in the field? What is their function?

Professionalism in this field has been slow to emerge and few universities and other teacher education institutions offer more than a single course designed to prepare teachers of gifted children. Through the National Defense Education Act, Counseling and Guidance Training Institutes have been established for training counselors to work with the gifted. Both teacher and counselor education programs have been handicapped by a lack of an established body of knowledge and

a lack of interest in accumulating such knowledge. Thus, there exists no group of adequately trained professional workers in this field. The major professional organization is the Association of Educators of Gifted Children which is a part of the Council for Exceptional Children. Considerable research has been stimulated by the Cooperative Research Program of the United States Office of Education. As this knowledge accumulates and as concepts of giftedness expand and develop, it is perhaps inevitable that we shall undergo changes in the near future.

Can the gifted child be encouraged? How?

Certainly, the gifted child can be encouraged. Fundamentally, this is done by attitudes and values which demonstrate to the gifted child that his talents are really worthwhile. It involves being respectful of the questions children ask, especially the unusual and searching ones. Adults must be respectful of the unusual ideas that children express, and make use of them to enrich the home, school, and community. Children need to be shown that their ideas have value, even now. They must be provided with opportunities for self-initiated learning and given recognition for this kind of achievement. They also need "time out" and periods for nonevaluated practice or learning during which they can afford to make and correct mistakes. Above all, do not overwhelm gifted children with rewards or expectations. A major problem is to stay out of their way and not throw their development off course by undue interference.

What are the attitudes most valuable to parents in dealing successfully with the gifted child?

Attitudes of understanding and respect, not awe, are most important. Parents, as well as teachers, should be respectful of the questions, imagination, explorations, unusual ideas, experimentation and testing, etc., of the gifted child. They should free the child to develop his talents and make it possible to do so by providing him with opportunities to use his resources (to try out his ideas, to inquire, to explore, to examine, to challenge and question, to doubt, to express his ideas).

Do gifted children usually become well-adjusted, successful adults?

According to the work of Lewis Terman and others where I.Q. has been used as the measure of giftedness, such children tend to become

well-adjusted, successful adults. The I.Q., however, has in it elements of conformity not present in a number of other measures of giftedness. Current studies of children displaying other types of giftedness indicate that such children frequently find themselves "in trouble" during their elementary and secondary school years. To determine what they will become, we must await the results of longitudinal studies now under way.

Can parents do anything to foster creativity in their children?

Perhaps more than anyone else, parents can do much to foster creativity in their children. Basically, they must value creative behavior and creative kinds of achievement. They can make their children more sensitive to the world about them, encourage the manipulation of objects and ideas, still teaching them to test their ideas systematically. They must themselves be tolerant of new ideas and avoid forcing any kind of set pattern for carrying out creative ideas. Parents can help children by teaching them to value their ideas and developing in them some of the skills for avoiding or withstanding peer pressures to undesirable kinds of conformity. They can help by dispelling some of the awe of the masterpiece, the smoothness of the finished product. Parents can create situations that necessitate creative behavior on the part of children. They can provide for time for thinking without being rushed and should not expect children to be visibly busy all of the time. Parents need to make available to children the resources for carrying out some of their ideas, at the same time teaching them to accept limitations creatively rather than cynically. (See *Creativity*)

Does the gifted child learn to speak and read at an earlier age than the average child?

Frequently the gifted child learns to speak and read at an unusually early age. Some, however, by their very giftedness are able to satisfy their needs, even their curiosity needs, through ingenious nonverbal behavior. Children gifted in some areas may always lag in the development of their verbal skills.

What are some specific examples of early behavior that parents might recognize as signs of giftedness in their child?

Perhaps the first sign of giftedness in a child is an unusually high degree of manipulativeness and responsiveness to his environment.

Perhaps one of the first clear indicators of intellectual creativity in the young child is lying, usually labeled as socially undesirable. Many other indicators of giftedness may also be labeled as undesirable simply because they are inconvenient to the busy parent. Such behaviors would include: curiosity, overactivity, long periods of quiet, absorption in a task, insistence upon taking a closer look at things, and a tendency to construct all kinds of queer gadgets which clutter up the house. On the other hand, he may display such desirable kinds of behavior as: going far beyond assigned tasks, amusing himself with simple things in imaginative ways, occupying himself without being stimulated or motivated by someone, thinking of interesting ideas for the improvement of family life, and his sensitiveness to everything around him.

What might be predicted about the identification and development of the gifted child in the future?

It is predictable that our concept of giftedness will expand to include a diversity of kinds of intellectual talent and special abilities, not now accounted for in commonly used identification procedures. As we develop special programs and more effective techniques for educating these different types of gifted children, a larger proportion of our population can be educated to a higher degree than now seems possible. As we deepen our understanding of gifted children and their problems, education will become more humane and the total human being will have a better chance to attain more nearly its potentialities.

GRAPHOLOGY

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What is graphology?

Graphology may be defined simply as the "study of handwriting," yet that study is not so simple, for handwriting is as elusive and complex as the human nature it reveals. Gordon Allport and P. E. Vernon have defined it as "the art (and perhaps the embryo science) of determining qualities of personality from script." Or it could be called a psychological method with a technique of its own for the study of personality through the medium of handwriting.

The hypothesis that handwriting expression and personality functioning are intricately related is not new; indeed, it goes back to the Greeks and Romans, even to the ancient Chinese. Oddly enough, it is not a far step from this to the phenomenological approach to graphology, which regards the study of the expressive aspects of writing as the outward manifestation of inner processes.

With the growth of experimental depth psychology, increasing attention has been paid to expressive behavior as a means of understanding personality. Not only does personality function in space, it also functions in time. It is a dynamic relationship between organism and internal and external environment, with the individual as the nexus, displaying unity, consistency, and continuity, as does handwriting.

From this point of view, handwriting is a particularly valuable expressive gesture, for it is actually a gesture in space, frozen or congealed in time. It is also a gesture that can be read in depth, since handwritings can be studied from all periods of an individual's life-span.

Certainly the relationship of posture, gesture, and mannerisms to the highest brain functions, indicates the importance of understanding the meaning of gesture (which includes handwriting) in order to understand these functions. For what has been at one time an expression of the entire organism is "reduced" or standardized, as it were, into an automatic movement, mannerism, or gesture, that may reveal the dynamics of personality.

The study of handwriting is based, in the broadest sense, on the notion that the most striking characteristic of the animate organism is

"expressive movement"—the capability of spontaneous and rapid motor response to stimulation, internal and external, as a fundamental function in its adjustment to the world about. Indeed, it is this very concept that gives rise to the basic postulate of graphology that goes uncontested by all branches of psychology.

These considerations lead to the empirical pillars of graphology, and give credence to its overall concept:

Each handwriting is unique and is never duplicated. The physiognomy of handwriting, just like a person's face, retains its essential and identifiable characteristics throughout the years.

But handwriting, like personality, is continually in the process of change, inevitably reflecting the growth, maturation, and aging of the writer, as well as the effects of crucial events, cathartic, or traumatic as they may be. In spite of these changes, a person's handwriting remains forever and uniquely his. Moreover, it retains consistency of expression. The mode of execution, one's style—guided by lasting personal dispositions—is similar in speech, voice, gesture, general behavior, and handwriting. But, unlike the fleeting patterns of speech, voice, and gesture, handwriting has the peculiar advantage of fossilizing that expression, leaving a visible record for leisurely, minute analysis.

What is handwriting?

Handwriting may be defined as the communication of a message carried by our nerves from the brain to the hand. The fingers, the remotest parts of the body, act as the tool that transfers the message received from the mind onto the paper. Hence we have here an immediate recording of thought and at the same time a most direct form of self-expression.

That the skill of writing depends upon an area of the brain quite separable from the primary motor mechanisms is proved by the fact that a man who loses his right arm can learn to write with his left, or with his toes, if need be, or with any movable extremity, even by movements of the head. He does not have to form new brain patterns for writing; and before long his signature recovers its true character. For as Wilder Penfield and Lamar Roberts state, "The pattern of the signature and of the writing is in the brain, not in the hand."

With the epoch-making discovery in 1861 by the French surgeon Paul Broca, we now know that there is an area in the so-called dominant brain hemisphere that controls both language faculty (speaking, read-

ing, writing, comprehension of speech) and unilateral manual skill—the main components of the writing act.

Man seems to have acquired language and to have become right-handed at about the same time in evolution. Indeed, as Stanley Cobb remarks, "Man alone has this specialization of a leading hemisphere in respect to handedness and language."

What is writing?

Writing is the graphic counterpart of speech, and as such holds a place of supreme importance, second only to that of speech itself, as an essential means of communication within human society. It is the means by which facts and ideas can be exchanged, and plans, thoughts, and feelings made common knowledge to the reader and the writer, separated in time and space. (See *Communication and Mental Health*)

Almost all ancient peoples boast a god or Titan figure who discovered fire; and their literatures all sing of his great discovery in epics of grandiloquence. Similarly, the origin of writing seems to have been ascribed to divine or magic sources, testifying in one way or another to the fact (which we seldom stop to realize) that writing is surely one of man's most original and important intellectual discoveries.

With its origin shrouded in mystery, it was easy for writing to become a tool of priests and magicians who recognized in it a source of power over the "unenlightened." They determined who should or should not learn to write, and severely limited those who could. Even in more advanced societies such as early Sumeria and ancient Egypt, the priestly scribes maintained official custody of writing—hoarding the records, teaching other scribes, and building libraries. Indeed, there seems to be a line of heritage extending from the priests of Isis and Osiris down through Pythagoras and the Alexandrians to the Byzantines and the alchemists of the Middle Ages. Some of these "magic sources" were passed on to the first "scientists" who, in turn, developed still more complicated systems of communication—astronomy, mathematics, and modern cybernetics—which continue to mystify the lay public of today.

So much prestige still attaches to written characters that any reform of writing is met with hostile opposition—even in dictatorial countries like China, where the attempt to introduce the Latin alphabet has so far met with little success. And George Bernard Shaw's phonetic English alphabet has not even made a dent in English-speaking lands.

Yet the first attempts to express ideas graphically cannot rightfully be called writing at all; they belong rather to the history of art. Only

gradually did primitive man realize that his naïve rock drawings might be communicable. The transition is almost imperceptible between what is properly called representational painting and what is properly called the pictogram.

Significantly enough, the ideas of writing and drawing were identical in prehistoric Egypt and in early Greece, as is shown by the Egyptian word *s-sh* (to write, to draw), and by the Greek word *graphein*. (The word *graphein*, which means both "writing" and "drawing," gives us the root of many words connected with writing: pictography, calligraphy, stenography, iconography, graphology, etc.)

For a time, the two functions may have gone hand in hand. It has always been difficult to separate the need to communicate from the need for self-expression; and, as graphology shows, the dual nature of the writing act persists down through the ages, even in the most sophisticated writing systems.

At the root of all writing, then, stands the picture or what grew out of it—the pictogram—"picture sign" or "sense picture." It is certainly of later origin than gesture and spoken language and consequently was greatly influenced by them. Pictographic—later ideographic—symbols differ from the dynamic gesture mainly in their possibilities of greater precision, detail, and permanence. They may be regarded as a secondary language—secondarily representing the abstract ideas of time, space, and inner relationship that inhere in man's conception of the objects themselves so pictured.

But inevitably they also became associated with the sounds of the spoken language representing the same ideas, and gradually turned into phonetic, eventually alphabetic symbols. With this association, a strict order of signs following the order of the spoken word became imperative, and there followed the ensuing rules of direction of writing, spelling, and prosody.

From that time on, the history of writing consists of the changes in form, shape, and style resulting from the adaptation of the basic alphabet derived from the Phoenicians to the various languages of the West. These metamorphoses were further influenced by the writing tools and materials employed.

Though Chinese and Japanese writing remained in the ideographic stage, it too underwent considerable modification and refinement over the centuries as the cultural level changed with the times.

As to the popular belief that there can be no thought without language, psychologists recognize that thought tends to pass over instantly

into movement. Yet it is possible to think, for example, in concrete pictures instead of words. And as we have seen in this brief exposition of the development of writing, the written word is ultimately a fusion of picture and thought—most strikingly apparent in the ancient hieroglyph and the modern Chinese ideogram.

Nevertheless, writing, no matter what form it took, remained fundamentally an instrument for the expression and communication of "thought," embodying itself as such in "language."

Venerable as the history of writing is, and admirably as it has served mankind for these thousands of years, we must stop to consider how little the "writing event" itself is understood. The modern school of semantics has shown us how difficult sheer communication via the word, spoken or written, continues to be. We have yet to solve the problem of handing down ideas in an unadulterated form from speaker to listener, from writer to reader—how to make sure that "A" really understands "B." Most enmities in life are the results of misunderstanding. The example of the right-handed teacher who cannot understand the left-handed pupil is one of the most clear-cut illustrations of the differentiation in human beings.

Listen to Yankee manager Ralph Houk's concern for a fledgling pitcher: "I didn't want to take any chance that he'd hurt his arm or shoulder by pitching with an unnatural motion while favoring his side."

If our teachers and educators were to show the same understanding of "sidedness," among other factors, in training our young to read and write, we should be taking a giant step forward.

Who were the individuals important in the development of graphology?

To do full justice to this question, it would be necessary to sketch the whole history of graphology; better yet, to delve into the very origins of writing. For, interestingly enough, those ancient soothsayers and priests who divined the riddles of the first mysterious symbols of writing were actually the first graphologists. The process of interpreting hieroglyphics and ideograms is more closely related to the way a graphologist reads a script than to the way the layman reads modern writing. The layman is concerned only with the literal meaning. The graphologist sees not only the intended communication of the writer, but also the expressive gestures that unknowingly accompanied the communication: the graphic projection of unconscious meaning within the jumble of those lines.

Until writing reached the relatively refined alphabetic stage, only the specially trained priests and scribes could "read," that is, make sense out of the complicated assembly of pictogram-ideogram-phonogram, which then constituted writing. This awe and respect for the written word, that continued down through the ages until printing made literacy common, still abides in China and Japan. From ancient times on, Chinese philosophers have speculated on the special style that distinguishes the calligraphy of each writer, disclosing his character, disposition, and personality propensities—an attitude amazingly close to that of graphology today.

Though Aristotle, Suetonius, and others in ancient Greece and Rome had observed that aspects of personality could be seen in an individual's handwriting, it was not until the beginning of the seventeenth century that the first known systematic attempts to study and describe the relationships between character traits and specific graphic signs in handwriting were made in the West. At that time a study entitled *Ideographia* was published in Bologna, Italy, and a physician, Camillo Baldo, followed with a treatise presenting a method for judging the nature of a person from his handwriting. Though both of these studies fell into oblivion, they must have attracted some contemporary attention, because subsequently it became a practice for itinerant magicians and other wonder workers to go from castle to castle giving consultations on character by means of handwriting interpretation.

Through the next two hundred years, curiosity about possible revelations in handwriting stirred the imagination of poets, artists, and philosophers; and "amateurs" like Johann Wolfgang von Goethe, Honoré de Balzac, and Charles Dickens made a practice of analyzing handwritings, often coming up with sharp observations and personality portraits of startling accuracy.

Around 1830, there existed in France a group of ecclesiastics involved in handwriting interpretation to which the Bishop of Amiens, the Archbishop of Cambrai, and Abbé Louis J. H. Flandrin belonged. Their disciple was Abbé Jean Hippolyte Michon of Paris, who not only gave graphology its name, but by studying thousands of handwriting specimens also discovered the meaning of "signs," interpreted as outward indices of particular inner attributes.

One of Michon's successors, J. Crépieux-Jamin, broke away from the "school of fixed signs" as this system was later called. He shifted emphasis from the elements of handwriting—such as the forms of *t*

bars, *i* dots, hooks, and flourishes—to the overall aspects. "The study of elements," he said, "is to graphology as a study of the alphabet is to the reading of prose." He stressed the point that a handwriting must be perceived as a whole, to which each trait contributes in varying degree and with differing emphasis. This concept, much akin to the "Gestaltist" point of view, is generally termed the "holistic" approach, as contrasted to Michon's or the "atomistic" approach. The conflict between these points of view has marked the entire subsequent history of graphology.

During most of the nineteenth century, French investigators dominated the field of theoretical and applied graphology, but toward the end of the century, German scientists began to take the lead. New psychological insights regarding the phenomenon of writing came from the work of German physiologists and psychiatrists who instituted methodical investigations. Wilhelm Preyer was the first to deal with the relationship of graphic movements to mental processes.

The concept that handwriting is really "brain writing," a centrally organized function, was formulated by Preyer in 1895.

Georg Meyer, a psychiatrist, made a further important contribution by examining the handwriting of emotionally unstable persons. He held that since emotion expresses itself consistently through all realms of psychomotor functioning, this uniformity of expression is most significant in determining the relationship between writing, movement, and emotion. Meyer's suggestion that graphologists needed the help of a new science, "characterology," and a common vocabulary for the two fields, was taken up by Ludwig Klages.

In establishing laws and principles of graphology and characterology, Klages assumed a science of expression that postulates two forces within man: "mind," which binds and inhibits him, and "soul," which frees and develops him creatively. According to Klages these two forces, always dynamically at variance, influence all of man's behavior and are most crystallized in his "expressive movements"—a term coined by Klages—walk, gesture, gait, speech, mimicking, writing, and so on. All such bodily movements, actualizing the tensions and drives of the personality have a common "form level" or style that is consistent with the individual's general motor behavior and rhythm of movement. It is particularly in handwriting, where the movements between the two forces are permanently caught, that they are most accessible for study and interpretation.

A whole generation of German graphologists grew up under the

leadership of Klages. Ironically enough, though he helped give graphology a scientific standing, Klages also found ways of suppressing points of view and investigative trends that ran counter to his own.

One of his chief targets was the experimental work of Emil Kraepelin and his staff, who attempted to measure writing pressure and speed in normal and mentally disturbed persons with the Kraepelin scale. To Klages such psychometric techniques were inadequate; he claimed that graphology should be dealt with as a science apart, and studied by "psychologically minded" people. The result was that cooperation between graphology and medicine ceased for a considerable time, and graphology was surrendered to metaphysics and armchair speculation.

Fortunately, however, progressive forces were at work that gave new impetus to experimental investigation and clinical procedure. There was the research of Rudolf Pophal, a neurophysiologist, who studied the problems of writing function, particularly tension in handwriting. He classified personality types on the basis of essential differences in types of motor behavior as reflected in the motor patterns of handwriting.

Also during the mid-1920's, significant advances were made in Switzerland under the leadership of Max Pulver. In elaborating his theory of the symbolic meaning of the writing space, Pulver extended Klages' graphological system by applying psychoanalytic concepts.

Pulver gave handwriting a third dimension, as it were, adding depth to the usual two graphic dimensions, height and width (breadth). He equated depth with pressure—those movements that actually seek to penetrate the paper—in contrast to the movements seeking height and width.

In thus schematizing the writing field—or paper—he was able to relate the various movements and dimensions symbolically to the different levels of functioning in the individual. In other words, as Rose Wolfson points out, at each level expressive movement means something else, and its graphic indicator has to be interpreted accordingly.

Meanwhile in Hungary this writer (Goldzieher-Roman) analyzed the relationship of muscular coordination and the interplay of tension and release to the personality pattern. To objectify this study, she constructed a recording device, the *graphodyne*, for registering pressure and speed of the actual writing movement, through wave-form tracings.

In 1931 at the Institute for Handwriting Research, Budapest, with the use of the graphodyne, a longitudinal study was undertaken of the writing development of 2,000 schoolchildren, aged eleven to eighteen.

Graphodyne measurements, statistically analyzed, provided information about the developmental course of writing-speed and pressure over an eight-year period and the effect of sex, puberty, and maturation on the evolutionary pattern.

In the interpretation of the results obtained through the graphodyne, the author tried to span the bridge between mechanical and psychological orientation. The tracings are tangible evidence of the tensions frequently referred to by graphologists when analyzing specimens.

In the United States, one of the first experimenters with handwriting analysis was June Downey of the University of Iowa, whose book, *Graphology and the Psychology of Handwriting,* was published in 1919. Gordon Allport and P. E. Vernon of Harvard made a similar investigation in 1930, concluding that there is meaningful interrelation and consistency in the total expressive movement of any given individual. Thus, a rigid, inhibited pattern of behavior will be as evident in the manner of walking as in handwriting, and no less so in facial expressions and gestures. More recently these conclusions have been broadened and deepened.

In the 1930's Robert Saudek, seeking to modify the speculative trend of European graphology, relied more upon quantitative methods. Proceeding experimentally, he used microscope, pressure board, and slow-motion pictures to examine handwriting movements. He carried out experiments with the handwritings of persons of all nationalities and classes, analyzing the effects of different types of penmanship training. His publication, *Character and Personality,* the first journal of graphology to appear in English, aroused the interest of British psychologists and gained some recognition for graphology in the United States.

A decisive step toward the introduction of an objective method in graphology was taken in 1942 by Thea S. Lewinson and Joseph Zubin, who developed a system of scales, which they applied in a clinical manner to the handwritings of normal and abnormal individuals. Rose Wolfson, after participating in the Lewinson-Zubin experiments, applied the scales in an independent approach, dealing with handwritings of delinquents and nondelinquents.

Thus, during the past thirty years, progress in graphological research has been substantially furthered in two directions. One branch has sought to record and interpret graphic indicators that can be quantitatively evaluated; the other, to explore the dynamism of personality within the dynamism of handwriting.

Is graphology accepted as a study with scientific merit in the United States? In other countries?

Not only has the psychological examination of handwriting with a view toward assessing the individual's personality and motivational patterns long been accepted in European scientific circles, but it also holds a respectable place in many of Europe's institutions of higher learning.

In the United States the story is quite different. It is only with the recent heightened interest in the use of a variety of projective tests and measurements (with instruments), not far removed in nature from the interpretation of handwriting, that a rising interest is being shown in graphology, and with it may gradually come a greater degree of acceptance. Hospitals and clinics are beginning to be convinced of its potential use and value as a screening device, especially as one of a battery of tests.

Some of the reluctance on the part of American scientific investigators is no doubt due to ignorance of the tremendous strides made in European graphology; partly also to the distrust which stems from the association of such techniques with the discredited and pseudoscientific practices of the so-called occult sciences, phrenology, and related practices.

One need only to contrast the educational situation in France, Germany, Switzerland, and the Netherlands to realize that there are specific courses of training, high academic standards, even degrees or certificates in graphology that attest to the scientific background and reliability of the handwriting analyst.

Despite the validity of graphological techniques, the accumulation of scientific standards, and its acceptance abroad, relatively little interest has been displayed in its adoption in the United States. Outside of lectures at The New School for Social Research in New York City, there is virtually no other course of graphology given as part of the curriculum of an accredited college or university anywhere in the United States. Moreover, there is no set of academic standards to attest to the background and reliability of the handwriting analyst. As for sorely needed scientific research opportunities, these are practically nil. Surely if we are to progress, we must revise the status quo.

Yet it is encouraging to note that there is a healthy increase in interest that may well lead to a better understanding of the potential value of graphology, and that this in turn will no doubt promote and

stimulate research. Indeed, the day may not be far distant when the fully trained graphologist will work side by side with the clinical and forensic psychologist.

What facets of the personality or character can be determined through graphology?

Assuming that the graphologist is a well-rounded individual, adequately trained in his own field, as well as having a background in general and abnormal psychology plus some knowledge of physiological psychology, complete individual personality studies can be made, either of a cross-sectional or longitudinal nature, provided adequate handwriting material is available.

The cross-sectional individual case study provides a practical description of the individual, his attitudes and his pattern of behavior at the time the writing was produced. The longitudinal study uses consecutive handwriting samples for serial study and provides information about the changes in personality occurring over an extended period of time. It may also pinpoint crucial or possibly traumatic moments in a life history through marked, dramatic changes in the handwriting.

It is important to realize that handwriting analysis is more a descriptive than a diagnostic technique. Nevertheless, it lends itself admirably to differential diagnosis in those cases of speech disturbance such as stuttering and cluttering that are reflected in equivalent graphomotor disturbances in the writing. It may also assist in the choice of appropriate remedial therapy.

What does the graphologist look for in the handwriting?

By concentrating on handwritings, one can develop the natural faculty of empathy, possessed in some measure by every person, for understanding graphic expression. One can also refine intuitive sensitiveness to such a degree as to hit upon disclosures that go beyond those to be obtained by psychometric and other rigidly controlled and standardized procedures. For some practitioners, this intuitive ability suffices. But the scientific mind feels the need of objective principles by which to check subjective perceptions and to clarify their vague, hit-or-miss impressions.

Briefly, proper graphological procedure involves these basic steps: viewing the writing pattern as a whole in order to grasp its essential overall expression; closer scrutiny of the pattern, breaking up the whole

into its component parts and differentiating the various constituent factors; taking the individual features and correlating them with the personality factors they stand for; then ordering them all into related groups and synthesizing them in the context of the whole; and finally, structuring from the components thus differentiated and defined, an integrated, dynamic personality picture. It should be emphasized that it is never the form of single letters alone, nor any particular characteristic, but the combination and interaction of all parts of the writing pattern that reveal the personality of the writer.

We might say that handwriting is simply a sequence of written symbols bearing a message from the writer to the reader—the written counterpart of speech. This verbal communication transmits a message which, to be understood, must follow a high degree of convention, a certain form of order, a pattern, in short, a code, something that has to be learned. How the individual writer copes with this code, that is, his "verbal behavior," is a matter of social as well as individual conduct. Thus even on the literal level, handwriting may be most revealing. Spelling, letter forms, style arrangement, as well as the intentional content, all tell much about a writer.

The graphologist sees all this, of course—the literal as well as the social aspects of handwriting—as an "intended communication." But he also sees much more. Looking deeper, he discerns how emotive and unconscious factors have also shaped this hand. In other words, he reads the accompanying "unintended communication," a language without words, simultaneously with the intended.

Thus in analyzing the written message, the graphologist distinguishes "three levels of functioning": .

1) The informative level or intended communication.

This is the first, most obvious level of functioning. We refer here to the intended, linguistic, verbal, informative aspect: the social message transmitted by written words. This, the conscious level, is the part that interests the graphologist the least.

2) The emotive level or unintended communication.

This second level is far more revealing to the trained eye. Here we find the sublinguistic communication of mimic and gesture, that language without words, the involuntary immediate outlet of expression that accompanies the act of writing, and shapes and colors it just as the varying intonations of the voice do, and such uncontrolled expressive gestures as smiling and frowning illumine and color our speech.

We have here a basic mode of communication that does not have to be taught, conveying as it does the immediate self-expression through involuntary tensions and motions.

3) The unconscious projection level.

This is the level where images, slips of the pen, twists, and inarticulate elements pop up or linger, hidden within the graphic pattern of letters and lines. It is up to the graphologist to ferret them out. These "fugitives of the unconscious," as Werner Wolff calls them, are the most difficult and taxing aspect of handwriting analysis, and must be approached carefully, with a technique similar to the psychoanalyst's when deciphering a patient's dream.

This, then, is what the graphologist looks for in a handwriting: the special combination and dynamic interplay of purposive and unconscious factors that determine the individual expression of the handwriting. That is why graphology holds handwriting to be a significant "expressive movement" as well as a "projection of the unconscious." It is also on this major assumption that we build our whole system of graphological analysis.

What are the advantages and disadvantages of graphology as a measure of personality?

So far it is the only test procedure that can be taken without the presence and immediate participation of the testee, thus avoiding the tensions and anxieties of the ordinary testing situation. All that is necessary are the handwritings. (See *Psychodiagnostic and Personality Testing*)

Now, with the proper specimens at hand, it is possible to determine personality functioning in the present; and with specimens spread over a period of time, a chronological "history" of the writer's development can be obtained.

Perhaps graphology's most practical asset is the way it lends itself equally well to group screening and individual case study. With it, it is possible to evaluate the writer as a member of a functioning group in a dynamic relationship—as part of a family, for instance, or a student in a class situation, or as one of a gang.

The intensive research of the past few decades has equipped the well-trained and clinically oriented graphologist with shortcuts to the quick recognition of key syndromes.

Distinguishing traits such as left-handedness, speech or voice disorders, ethnic gestural patterns, occupational habits or skills—even the

country where handwriting was first learned—can be easily discerned.

Moreover, in group screening, the grossly normal can be easily separated from the disturbed, thus quickly classifying the range of testees. Indications in the handwriting of particular behavior disorders furnish clues for differentiating among clinical groups (e.g., functional psychosis, organic conditions, and other psychopathology); while among potential offenders, it is possible to pick out, just as in a police lineup, those whose specific personality type fits a specific crime.

It would follow that graphology has great advantages in the screening, hiring, and upgrading of employees in business and industry. The participant has no knowledge of the process of comparison and evaluation; and a trainee's progress can be recorded without his being aware of it. Also, the employer's handwriting can be judged as well as the employee's. This is particularly valuable when it is important that the salesman "speak the same language" as his boss.

Finally, graphology is one of the few measurement tests with a predictive capacity. A good graphologist can discern potential through analysis.

On the other side of the ledger, we must not forget the lack of qualified practitioners who can be entrusted with this subtle and difficult technique so easily subject to abuse and misuse. Then, too, in graphology, as in surgery and other specialized techniques, talent is an all-important essential. The most expert training will not necessarily make a good graphologist out of a nonempathic individual.

Can aptitude be determined through graphology?

There is a considerable body of research directed at evaluation of graphology as a diagnostic tool for determining specific aptitudes, but without any very conclusive results. While there is every indication that some graphologists perform well above chance, graphology's unique assets in predicting aptitude might better be employed elsewhere.

This is an important issue because it is precisely within this framework that the amateur graphologist is likely to pin his hopes for easy assessment, and thereby lose his bearings.

As Daniel S. Anthony has pointed out, many, perhaps the majority of recent aptitude tests are better measurers of special aptitude than is graphology. For example, graphology cannot compare with the revised standards for clerical, mechanical, accountancy, or engineering aptitudes, to mention only a few. For the kind of intelligence it purports

to measure, the Wechsler-Bellevue Intelligence Scale provides an adequate criterion of intellectual functioning and conventional knowledge. Graphology is more useful when it comes to the assessment of the total and interpretative functions of the personality in static or dynamic actuality. (See *Aptitude and Vocational Testing*)

Can age and sex be determined through graphology?

Experiments made and reported by Alfred Binet in 1904 with J. Crépieux-Jamin participating, demonstrated that neither the chronological age nor the sex of a writer can be determined conclusively from his handwriting alone.

This is hardly surprising since it has long been known that discrepancies between chronological age and degree of biological and psychological maturity are to be found in many individuals. These discrepancies are invariably reflected in handwriting. Thus the handwriting of many young people shows early maturity, while that of others up to college age and even beyond is quite immature, even childish. Senescence (old age) does not set in at any fixed time, nor does the appearance of any of its graphic indications. Crépieux-Jamin also introduced the concept of "age of writing culture," which corresponds to I.Q. or to level of achievement and is similar to Binet's widely used developmental curve, the "mental age," based on a particular level on a scale of intelligence tests. For example, a six-year-old may have a nine-year-old's capacity. His chronological age would be six, his age of writing culture, nine.

Are there standard signs that might indicate certain characteristics?

No single trait or feature of handwriting can be interpreted without reference to all the others, even though for purposes of analysis, the graphologist may set them apart, down to the smallest detail, and view each one technically by itself. Yet no modern graphologist would claim that any one graphic feature or "sign" has in itself any fixed meaning. Valuable as the pioneer work of Michon and his followers was, with their dictionary of isolated "signs" and their supposed meanings, we have by now left that far behind.

While some implication of a given single feature may serve as a guidepost pointing to one possible interpretation or another, the single trait as such is significant only in relation to the group to which it belongs. Certain features may suggest meanings that reinforce the implications of others. Conversely, some traits may suggest meanings that

conflict with, weaken, or neutralize the bearing of others. Therefore each feature must be weighed against all the rest, and against the general expression of the total pattern.

Nevertheless, it is interesting to note that there is no universal rule. We have only to contrast the practice of the Viennese graphologist Roda Wieser, who reduces everything to one overall characteristic—"basic rhythm"—and Heinrich Pfanne, who lists four hundred subgroups.

Can graphology be used alone in making a psychological test of an individual?

Yes, indeed. As a matter of fact, no other projective technique offers the marked advantages of graphology as a sole means for total personality assessment.

Unfortunately, there are not anywhere near enough adequately trained graphologists in America today who can fill the bill—persons who are equipped to give through graphological analysis as complete a picture of the personality in its functional action and reaction behavior patterns as other single psychologists can produce using multiple testing devices.

What are the practical applications of the study of graphology?

Since the majority of these questions are concerned, in one way or another, with "practical application," we shall simply list here the many uses of graphology:

a) In clinical testing: to supplement a battery of other tests.

b) As an auxiliary to psychiatrists: both for what it can reveal about the patient before treatment and for checking his progress during treatment.

c) In courts: for handwriting identification and authentication of documents, as well as for providing information about the personality of the defendant; also for checking the behavior of parolees.

d) In education: to help the educator obtain insight into the personality of the child and to help follow changing phases of his development; to detect disturbances before behavior difficulties arise (in other words, preventive therapy); in cases of treatment being administered, to follow the hoped-for results of treatment, whether medical or therapeutic. Furthermore, the teacher with a graphological background will be better able to understand and cope with any problems

related to reading, writing, and speech difficulties, as well as to problems of handedness.

e) In social work: as an adjunct to vocational guidance, it can help the social worker determine the needs and desires of the individual consulting him and to relate aptitudes to inner motivations, etc.

f) As a guide in the restitution and retraining of aphasic patients.

g) In business and industry: for rapid screening and selection of personnel; also as a guide in determining the rate and nature of promotion—in other words, as an aid in hiring and firing.

h) And in many fields as yet untapped.

Is the testimony of the graphologist held to be valid in court?

The examination of handwriting with a view toward determining the authenticity of documents and signatures has been employed by the courts since the last century, and the questioned handwriting examiner accordingly has carved for himself a significant niche in the courts. The use of handwriting, however, as a means of probing the individual's personality has been regarded with considerable suspicion and skepticism by American courts and law enforcement bodies, and indeed, by academic criminologists as well.

In Europe, on the other hand, considerable weight is attached to what the graphologist has to say about the personality as well as the identity of the writer. Graphologists appointed to the courts are given legal documents like those given to lawyers, and are allowed to cross-examine witnesses. Moreover, studies of the handwritings of criminals by such graphologists as Max Pulver and Roda Wieser (the latter, handwriting examiner to the courts and police of Austria) are treated with respect.

Regrettably, American criminology, though willing to avail itself of help given by other projective techniques, has been reluctant up to this point (though there is a move in this direction) to apply graphology to the same problems.

Is there a difference between the "questioned document examiner" and the graphologist called upon as an "expert witness"?

Yes. In the United States, the questioned document examiner generally confines himself exclusively to determining the authenticity of documents and signatures through the technical examination and the calligraphic comparison of questioned handwriting specimens; whereas the graphologist is an expert of a different sort, more concerned with

the psychology of handwriting and the motivations of the writer than with detailed comparison of similarities and dissimilarities.

Of course, it is to his advantage if the questioned document examiner also has some knowledge of the basics of scientific graphology (as is generally the case in Europe). This is nowhere better illustrated than by Arthur J. Quirke, Handwriting Analyst to the Department of Justice of the Irish Free State, and author of *Forged, Anonymous and Suspect Documents*. Taking an analogy from medical practice, he maintains that a handwriting examiner who works upon a calligraphic basis only, and has no knowledge of the fundamental principles of graphology, bears the same relation to the graphologically trained analyst as the ordinary midwife to a skilled obstetric surgeon.

How can one receive training in graphology? What are the qualifications for a scientific graphologist?

Ideally speaking, the scientific graphologist should have a thorough background in both general and abnormal psychology, in education, and in social work.

The special scope of graphology also necessitates, as part of a balanced preparation, some knowledge of physiological psychology, particularly an adequate comprehension of the neuromuscular mechanisms underlying the act of writing.

The graphologist also needs the gift of empathy, and a knowledge of human individuals in both their biological and psychological make-up, seen against the background of the social and cultural milieus in which they have their being. In other words, a qualified graphologist should be a well-rounded individual, acquainted with all strata of existence and aware of the full sweep of life. His educational orientation must be as broad as possible to assure understanding of a wide range of people.

It is interesting to note that in Switzerland where a graphologist spends three years on the college level in the University of Applied Psychology, he is now required to have a Ph.D. before he can become an officially licensed graphologist.

Can graphology be used to diagnose mental disorders?

No, definitely not. The graphologist has no business stepping into a field for which he has no training.

Just as the practice of graphology relies upon insight gained through

clinical and psychoanalytic approaches, as well as general experiences drawn from normal and abnormal behavior, a handwriting analysis may be a welcome addition to the exploration protocol of the medical doctor.

Even in such cases, the graphologist should resist the temptation to elaborate his findings in medical terminology. His cooperation will be all the more effective and appreciated if he confines his report to an easily readable, accurate, and objective picture of the personal qualities and behavior pattern of the subject—a living, breathing human being.

Can graphology be used in the study of physical disorders and disease?

1) The use of handwriting analysis in the study of disease involving the neuromuscular system, directly or indirectly, has now reached the stage which justifies the use of the term "medical graphology" to describe the technics.

2) One of the most distinguished accomplishments of the psychology of handwriting has been its contribution to the study and understanding of language disorders and problems of handedness.

3) Graphology has already proven its worth as an invaluable aid in the remedial therapy of "aphasics": the restitution and retraining of the lost capacities of language, including all aspects of reading, writing, and speech. For the proper handling of such a patient, and the evaluation of his defect, the therapist can call on the handwriting analyst to learn as much as possible about the premorbid constitution of the patient and his personality as a whole, the modification of all these factors by pathology, the patient's capacities outside of speech, whether undisturbed or damaged, etc., and finally to provide a realistic appraisal of the situation in which the individual has to live.

4) One of the landmarks of graphological research is the study of the handwritings of 283 pairs of twins undertaken in the Medical School of Budapest in 1942. The investigation provided evidence that the dissimilarity in the handwritings of identical twins is due to a difference in lateral dominance, since in most cases one twin proved to be right-handed and the other left-handed. This graphological finding was verified by clinical examination of the subjects. Prior to this research no explanation of this phenomenon had been advanced, although the question had been raised by Francis Galton, the founder of the science of human genetics, as far back as 1883.

This line of graphological research, sometimes called genetic graphology or grapho-genealogy, is a field open to further investigation and one likely to yield rich results. It promises to shed light on the relation between heredity of physical or mental attributes, on how they are transmitted from one generation to another, as well as on the inherited attributes to which an individual is predisposed by the presence of a certain gene or combination of genes.

The twin research also has obvious bearings on the problem of handedness.

Can an individual successfully disguise his handwriting?

It is rare indeed that the disguise adopted is more than superficial, and in most cases, it covers only a small number of characters and special habits exemplified. A change in slant and changes in a few forms (capitals, lower loops, and the like) are often the only disguises attempted. While these may affect the general appearance of the writing, it can easily be seen that the character of the script remains practically unchanged. Assumed illiteracy, distorted letter forms, and the use of pen printing are typical procedures. But as soon as fatigue sets in, the natural forms pop out, so that the longer the document, the easier it is to determine authenticity.

Is there any connection between legibility and intelligence?

Not intrinsically.

Can a graphological evaluation be misused or misinterpreted?

Certainly. Like any other clinical test, it must be used with discretion, understanding, and know-how. You would not entrust a doctor's prescription to an untrained pharmacist.

Here, indeed, is where most misunderstanding of graphology enters in. There is the psychologist, for instance, who perhaps without the least background in graphology, sets out with his rigid but invalid methods to check the "validity" of graphology. This is comparable to having a freshman in medical school check the validity of an X-ray picture or an electrocardiogram. Neither has the slightest idea whether what he is looking at is "right" or "wrong."

Finally, there is the use and abuse of graphology by amateurs and pseudoanalysts, which has so long delayed the acceptance of the truly scientific methods of the psychology of writing in this country.

What could be predicted about the status and use of graphology in the future?

The picture is certainly brighter than it was a generation ago.

In Europe, where graphological science has long been accepted, there has been steady progress since World War II, especially in France, Germany, Switzerland, and the Netherlands.

The French school, in analyzing handwriting, is intent on noting each subtle nuance and detail, seeking to establish standard graphological and functional types, based on psychoanalytic insights, with special orientation toward Carl Jung.

French psychologists also seem to have made considerable strides in the use of graphological techniques for large-scale testing and promotion guidance in industrial plants, assigning workers to the jobs they best fit, and promoting them according to their talents.

Less pragmatic is the graphologically inclined German *Betriebsconsultant* (an operations efficiency expert in a large factory or business firm) with his methodical, synthetic approach, concentrating on personality structure.

While it is encouraging that in both Germany and Switzerland courses in graphological theory and the interpretation of handwriting form an integral part of the academic curricula in psychology, and are also included in the study of medicine and criminology, it is disappointing that the awe for Klages still impedes the course toward a genuine and fruitful rapprochement between psychiatry and psychology in German-speaking countries.

On the other hand, there are medical centers (Düsseldorf) where graphology is being incorporated into clinical investigations. The research carried out in regard to psychomotor evidence in writing (Gerhard Grünewald) shows a promising beginning for exact methods of graphological diagnosis in the field of pathology.

Work on the comparative consideration of speech and writing to advance understanding and knowledge of language function is being pursued on both sides of the Atlantic. Articles published here on this subject are immediately reprinted or at least summarized in journals overseas.

In far-off Israel, a solid outpost of graphology is in the hands of R. Pokorny, who publishes one pungent paper after another, all pointing to "exactness in graphology" and serving as an antidote to the plentiful output of "armchair psychology" that tends to crowd the graphological journals.

But there is one geographical area where handwriting research is not yet accepted—Russia—where they still say *nyet* to "this decadent phase of bourgeois psychology!"

What is handedness?

It is the preferential use of one hand over the other, showing the functional supremacy in muscular strength and skill of the dominant or master hand.

People are distinguished as right- or left-handed according to their lateral dominance. The great majority of people are right-handed, using the right in manipulating objects, and employing the left only as an auxiliary; the minority are left-handed. (Those who seem to use both hands equally well without selective preference of a master hand are called ambidextrous. However, the ambidexter is usually a genuine left-hander who has acquired bimanual skill.)

Graphology naturally comes into its own whenever problems or questions arise with regard to handedness. In studying what causes an individual to act either as a right- or left-hander, it is important to know something about the mechanisms of the brain in language function; for the concentration of the control of speech, reading, and writing in one half of the brain (the dominant hemisphere) bears an intimate relation to the development of unilateral manual skill in the individual, more commonly known as "handedness." It all seems to be part and parcel of that unique physiological pattern—the special attribute of those faculties that have done most to give man his commanding position in the animal world.

It is also important to bear in mind that functional supremacy of one brain hemisphere is clearly demonstrable only in man, and even in man this specialization is to be found only in the language faculty and the more intricate manual skills. For many of the simpler activities of the brain, the relation of the two hemispheres to each other, while a variable one, is quite different from that underlying the verbal abilities—speech, reading, or writing.

Research shows that the infant at birth starts with no unilateral superiority in control of either hand or language, as far as we can determine. Yet undoubtedly most children carry a hereditary tendency to develop the predominant use of either the right or the left hemisphere. This is confirmed by genetic studies of Samuel Torrey Orton, showing the occurrence of handedness in families and the persistent appearance of left-handed individuals in all races in spite of many generations of

directive training and strong social pressures toward the right hand.

Handedness is so freely open to the influence of training, however, that the resultant patterns one finds tend to be a combination of the hereditary bent and the effects of training. Numerous studies on the influence of education and "writing drill" confirm this observation. Pressure exerted on the innately left-handed child by family and school results in a large number of "apparent" right-handers. Social, vocational, and economic pressures, as well as environmental disadvantages, (most machines and tools being designed for the right-hander) work further havoc on the left-hander.

These factors easily lead to "shifts of handedness." Such shifts may be accomplished more or less successfully, but generally at a considerable toll of anxiety, tension, and real effort to the left-hander.

Actually, the left-hander is most comfortable in mirror writing, where direction and letter formation conform to his inverted spatial orientation.

In mirror writing, which is the natural writing pattern of the left hand, the script starts on the right side of the page and proceeds from right to left with reversed order in spelling and at turning the letter image. The sequence of letters in the word *was*, for example, is perceived as *saw*, the mirroring of *p* as *q*, of *d* as *b*.

This happens because both of the brain hemispheres operate in reaction patterns of contrary motor orientation and reversed configuration. Thus, if both hands carry out corresponding muscular movements, the contrary inner orientation, as well as the reverse position and function of the muscles of the two hands, compel one hand to perform the mirrored action of the other. You can demonstrate this yourself by trying to write simultaneously with both hands, preferably on a blackboard.

A famous example of mirror writing is in Leonardo da Vinci's diary, written with his left hand; whereas his correspondence, written with his right hand, looks like any ordinary handwriting.

Any attempt to shift "innate" handedness to the opposite side is an unwarranted interference with a natural function. Modern experimental research shows that even the most skillful on both sides might have been more facile had they been trained in accordance with their own natural physiological bent. Children who establish preferential handedness early are also early in showing well-developed signs of psychomotor maturation.

There is further a fair uniformity of opinion that a person not en-

dowed with a pronounced selective preference for one side in all motor activities is prone to spatial disorientation and confusion in left-right directed mobility—the specific discipline essential for reading and writing.

Is there a relation between handwriting and language disorders?

It has been known for some time now that there is a most significant correlation between certain disorders of speech and writing, which is especially obvious in cases of stuttering and cluttering. Graphology has been particularly valuable in showing how such disturbances are reflected in the handwriting by equivalent graphomotor disturbances. It follows that a sensitive handwriting analysis can considerably aid the differential diagnosis of the disturbance and clarify the prognosis of improvement. It may also assist in the choice of appropriate remedial therapy.

To treat a writing defect in a child simply as an aspect of dullness or stupidity, as often happens, is to make a serious mistake, often with traumatic results for the boy or girl. The importance of making a correct diagnosis thus becomes evident for anybody who is vocationally involved in education—teacher, psychologist, or doctor.

The more forward-looking clinics in the United States and Europe are now convinced that disturbances of speech, hearing, writing, and indeed most forms of communication, cannot be studied or treated in isolation from the total personality. Here again graphology is being called upon to help complete the "Gestalt."

GRIEF

by ERICH LINDEMANN, M.D.

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What is grief?

Grief is the state of pain, discomfort, and often mental and phys-
ical impairment that in most persons follows the loss of a loved one.
It is marked by the painful feelings of sorrow, loss of appetite and
sleep, a sense of excessive fatigue, and a general state of mood depres-
sion. While sorrow is the pain and misery attending the state of griev-
ing, we think of grief itself as an active state of adapting to the loss
of a dear one by a special kind of psychological work. Sigmund Freud
called this "grief work."

Is grief associated only with loss by death, or can one grieve in abandonment?

The loss that precipitates mourning and grieving is most com-
monly the death of a person important in one's life. However, it may
also be the loss of another person who has jilted or disappointed one,
or just by geographical removal of the other individual. An important
form of grieving must also be expected after the loss of a part of one's
body such as amputation of a limb or the removal of an eye. It is pain-
ful and requires adaptive work to lose a part of one's body. Finally,
leaving home and parents at the end of school or even leaving one
place of work for another may often be followed by unrecognized
forms of grieving and mourning, that go under the name of homesick-
ness and promotional depression.

Is grief for a dead child different from all other kinds of grief because the child represented one's own creation and one's hope of immor-tality?

One of the important aspects of grieving is an intense identifica-
tion with the person one has lost. Mothers who have lost a small child
often show particularly severe forms of grieving because it seems to
them that there was no clear separation from the child in their self-
awareness.

Can one share the grief of another's bereavement?

We must distinguish grieving from sympathetic understanding and suffering with another person who is in deep distress at the time of mourning. Participation in "grief work" through discussion of the deceased and of the experiences which the mourner had with the deceased, can be very helpful indeed.

Do men and women bear grief in different ways?

The basic grief reaction appears the same in men and women. However, women are often prone to express their feelings more readily than men, and many appear more unhappy.

Can a child experience grief?

In small children the sense of abandonment or the dread of losing the mother or mothering person appears to be the most important state of distress. Much recent work on orphaned children and children in hospitals has shown the state of paralysis and apathy resulting from a separation from parents and family. A child might often be disturbed, even after being reunited with the parents, in order to discharge the emotional tension that has been built up.

Is it possible for one to grieve so deeply that one dies of sorrow, of a "broken heart"?

It has been shown that many persons, who in adult life develop psychoses or neuroses, have lost their mother before the age of five. It also occurs not infrequently that a mental disease becomes manifest shortly after the loss of another person. Investigation shows that the person who became sick had an especially close and dependent relationship to the individual whom he lost. Similar observations have been made on certain psychosomatic illnesses such as ulcerative colitis.

Can it be called true grief if the lost object is a thing, such as a pet animal or a doll?

Severe loss reactions have been observed in children after the loss of a doll which had become an important source of comfort. This also occurs in lonely individuals after the loss of a pet animal.

Is grief when mixed with guilt more difficult to bear?

Grief reactions after the suicide of a loved one are particularly difficult; also those in which an accident or illness occurred that might

have been prevented. Under such conditions, the survivor has to come to terms with his remorse and guilt feelings before genuine grieving can take place.

Is grief more easy to bear in a situation where the loved one had been suffering without hope of improvement or surcease?

Grief is often particularly severe after caring for another person during a long terminal illness. Here the fact that so many daily activities were concerned with the loved one and now have to be replaced by activities involving other persons appears to be the major task for the mourner.

Can a disaster be so enormous, such as the simultaneous death of several members of a family, that grief cannot be experienced, and only numbness exists?

There are, indeed, a number of individuals who after a severe loss find it impossible to experience normal grief and mourning. The absence of such reactions, when they should properly be expected, should alert the observer to grieving that might occur much later or to a grief state that may be replaced by neurosis or psychosomatic disorder.

What can be done to ease the burden of grief?

Much can be done to help the mourning person to mastery and readaptation after a severe loss. It seems important to have an opportunity to express the deep emotion that is part of mourning and to have a chance to review the experiences and activities which were previously shared with a lost person. The eulogy and traditional ceremony are often helpful in bringing together friends and relatives to discuss aspects of the lost person's life and to give the mourners a chance to express their feelings without embarrassment. The real work of adaptation, however, usually starts later when the survivor finds himself alone in his efforts to cope with the new situation. Continued friendly contact and more opportunities for talking about the loss are then helpful.

Does plunging oneself into work help to relieve grief?

Some persons believe that hard work will cure any emotional strain. It is possible to suppress the mourning reaction, but most societies provide wisely for a mourning period during which a person is allowed to experience his loss and to learn to cope with the intense feelings of mourning—to do his "grief work."

Does belief in an afterlife tend to lessen grief?

Religious beliefs are often very helpful to the person who is devout, especially those beliefs assuring him of the continued existence of the person whom he has lost. They may help postpone facing the gravity of the actual loss in one's personal life but will not spare the necessity of finally coming to terms with the fact that new roles have to be found and new relationships have to be developed.

How does grief diminish and disappear?

Mourning under fortunate circumstances is resolved over weeks and months if the "grief work" is done successfully; that is, if the emotions have found expressions and if the activities and roles that involved the lost person have been reorganized, so that a new relationship with other persons can take care of the needs previously satisfied by the person now dead. This is more difficult when the deceased person satisfied almost all the needs of the surviving person and when there rarely had been opportunity to turn from one relationship to another as different roles developed during the mourner's life.

When grief does not diminish, what help is available?

Under these circumstances, psychotherapy in the hands of a psychiatrist can help the patient discover for himself the psychological skills of effective grieving. Many clergymen through wise counseling and through their own understanding of the processes of bereavement can render valuable assistance to the mourner. Help to the mourner is extended best by counsel and assistance in mastering the life crises. This is quite different from special methods of therapy for neurosis or other mental diseases. In dealing with the latter conditions, both psychoanalysis or hypnosis may be indicated as special forms of treatment. This will be true for mourning only if it occurred in a patient suffering from an emotional disorder.

Are some persons ashamed to realize that they have adjusted well to the new life and are, perhaps, even beginning to be happy again?

Proper assistance through the mental health worker may, indeed, help a mourner so effectively that he will adjust well to the new life situation, and sooner than he or the family expected. If in his particular ethnic or religious group a long mourning period is prescribed, he may feel hesitant to resume his healthy life activities before the end of this period. This choice can be readily left to his own decision because much depends on the details of his particular life situation.

GROUP PSYCHOTHERAPY

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What is group psychotherapy and what are its origins?

This term is used for all methods of psychotherapy in which several patients are treated at the same time. A few psychotherapists began to use group methods in the early decades of the twentieth century, but this approach did not achieve widespread popularity until World War II and after. At least two factors contributed to this upsurge. As psychotherapy became better known, and veterans were entitled to receive it, the demand far outstripped the supply of trained psychotherapists. The effort to stretch the services of the latter by treating patients in groups received added impetus from the increased sense of interdependence in national and international life. Under the impact of the enhanced recognition that "no man is an island," therapeutic concern came to include groups as well as individuals.

What is the underlying principle of group therapy?

All methods are based on the principle that persons are profoundly influenced by the groups to which they belong. To be out of step with a group with which one identifies oneself is very distressing, whereas the feeling of being accepted by such a group greatly strengthens a person's morale. Therefore, one tries hard to gain this acceptance by conforming to the group's standards and expectations.

Therapy groups capitalize on this universal human drive by fostering honest, intimate expression of feelings, ideas, and experiences in an atmosphere of mutual respect and understanding, thereby increasing the members' self-respect, deepening their self-knowledge, and helping them to get along better with others.

What are the major types of illness for which group methods are helpful?

Group therapies can be helpful in the treatment of all types of mental and emotional disturbance or behavioral problems, including

neurotic disturbances, psychoses, adjustment difficulties of every age of life from childhood to old age, and deviant or criminal behavior. The methods must, of course, be appropriate to the type of disturbance being treated and the treatment setting.

What are the major types and settings of group therapy?

Group therapies can be classified according to the settings in which they are held, the basis on which members are chosen, and the types of activity that go on in the group. Activities may be highly organized, as in directive group therapies, or largely unstructured, as in free-interaction or interview group therapies. Settings are institutions or hospitals, outpatient clinics, and therapists' private offices. Members can be either strangers or members of already existing groups, such as a family or patients in the same ward of a hospital.

Family therapy deals with natural groupings. It is based on the recognition that the patient's distress may, to a large extent, be both created and perpetuated by disturbed interactions with those closest to him. By working with the patient and his family as a unit, the therapist can observe malignant patterns of interaction, confront the family with them, and support and guide family members as they work out healthier ways of relating to the patient and each other. The potentialities and limitations of this relatively new approach have not yet been fully explored, but its therapeutic power for certain patients and their families is unquestioned. (See *Family Psychotherapy*)

Group therapy with hospitalized patients is often termed the "therapeutic community." This term comprises the use of a variety of group methods to enhance potentially therapeutic influences within mental hospitals. Frequent group meetings of various types serve to reduce institutionalized communication barriers between patients and staff, and between various staff echelons. Patients learn to express their feelings freely and to assume greater responsibility for their own functioning and the therapeutic program of the institution. These measures combat patients' sense of isolation, improve their morale, and teach them to manage their relations with others more effectively. Concomitantly, steps are taken to build up links between the hospital and the surrounding community to facilitate the patients' discharge. (See *The Therapeutic Community*)

This article reviews directive and free-interaction types of group therapy with nonhospitalized patients who are initially strangers.

What are examples of directive forms of group therapy with out-patients?

Four widespread programs are Alcoholics Anonymous, Recovery, Inc., therapeutic social clubs, and psychodrama.

What is Alcoholics Anonymous?

This is an organization composed of alcoholics and is a form of group treatment. This group treatment is conducted solely for and by alcoholics and is said to help about three-fourths of those who stay with it. Its strength lies in the intimate understanding that alcoholics have for one another and the emotional support they can give to each other. Meetings consist almost entirely of members' testimonials about how wretched they were when they drank and how much better they are now that they are sober. In this and other ways, Alcoholics Anonymous mobilizes strong group support for continued sobriety.

What is Recovery, Inc.?

This movement, founded by the late Abraham A. Low for his ex-hospital patients, has grown into a self-help movement for all types of patients able to function in the community. These groups inculcate certain principles of thought and behavior believed to promote mental health. Members are taught, for example, that although the external environment often cannot be changed, one's reactions to it can be controlled, and that judgments of right and wrong should be avoided since they are purely subjective and serve only to produce temper. Members learn to reject or suppress thoughts that create tenseness, to force themselves to bear the discomfort of doing what they fear, and to "endorse" (i.e., congratulate) themselves each time they use the methods of Recovery, Inc.

Meetings open with readings from Abraham Low's book, *Mental Health Through Will Training*, and are followed by testimonials in which members, using a prescribed form of presentation, describe how these principles helped them to handle more effectively various distressing situations. The testimonials and the discussions following them make much use of slogans. Thus Recovery, Inc. gives direct guidance and fosters a sense of group solidarity through repeated affirmation of common values and the use of a common language.

What are therapeutic social clubs?

This type of group therapy, promoted initially by Joshua Bierer in England but now widespread in the United States also, is especially helpful for patients trying to reenter community life after a period of hospitalization. The clubs are conducted by their members who plan, finance, and carry out organized social activities. Professional therapists screen members for admission and attend all meetings, but try to remain in the background and to function mainly as advisers. The chief aim of these groups is to increase their members' social skills as a means of enhancing their self-confidence and interrupting the spiral of low morale leading to social withdrawal and further loss of morale.

What is psychodrama?

This term refers to a large number of techniques in which patients act out, or watch others act out, personal problems. Psychodramatic group therapy evolved from J. L. Moreno's Theater of Spontaneity in Vienna in the early years of the twentieth century. He noted that an actor who created his own plays spontaneously tended to mirror "his private world, his personal problems, his own conflicts, desires, and dreams." Appreciating the therapeutic value of such an activity, Moreno evolved psychodrama by "systematically developing play as a thera- peutic principle." Psychodrama is an intuitive and artistic form of personal interaction employing an appreciation of the "social matrix" in which the individual (the "social atom") moves. Therapists and fel- low patients serve as both actors and audience. The patient's own thera- pist is the stage director and helps the patient select the problem to be acted out, chooses the other players, helps with the dialogue and action, and guides the discussion following each episode, in which the audience participates.

Two illustrative special psychodramatic techniques are: (1) role reversal, in which the patient plays a significant member of his family and another actor plays the patient; and (2) "the mirror," in which others portray the patient in his presence.

Because of their flexibility, psychodramatic methods are applicable to a wide variety of patients. The psychodrama may be planned in de- tail by the director with the aim of helping the patient overcome a specific difficulty. For example, to help hospitalized mental patients develop or recover the elementary social skills which they will need on their release, simple scenes are devised that involve shopping or

asking a prospective employer for a job. Usually the patient plays him-self and another patient plays the shopkeeper, prospective employer, and so on. The scenes are graded in difficulty so that the patient always succeeds. This helps to build his self-confidence as he learns to cope with increasingly challenging situations.

In another approach, the patient is encouraged to act out spontane-ously a personal problem involving persons to whom he is emotionally close, such as his parents or his spouse. The patient calls on others to help him as he goes along, and tells them how to play the roles to which he assigns them. As the playlet proceeds the patient and the other players act with increasing spontaneity in accord with the spirit of the drama. Frequently the members of the audience become vicariously involved, so that the situation may develop therapeutically beneficial emotional impact for both players and audience.

What is free-interaction or interview group therapy?

The types of group therapy identified by these terms all strive to evoke the maximum range of members' strengths and weaknesses, and place great emphasis on gaining insights. They probably dominate group psychotherapy in both the United States and England.

Free-interaction methods were developed by early group therapists such as S. R. Slavson, Paul Schilder, and Louis Wender in the United States, and S. H. Foulkes in England, within the theoretical framework of psychoanalysis, but the range of variation of analytically oriented group therapy soon became very great. Variations include stress on dreams or their neglect, emphasis on patients' reactions to each other in the group, on their personal goals, or on the recovery of infantile memories and fantasies. Techniques of leadership have included the use of co-therapists and have ranged from maximal passivity to contin-ual indirect control of the course of the session by the use of questions and interpretations.

A widespread form of free-interaction group psychotherapy is based on the "client-centered" orientation of Carl R. Rogers. In this the thera-pist makes very few interpretations and tries primarily to promote in-creasingly open and nondefensive interactions of the members as a means of helping them to achieve heightened self-understanding and emotional security.

All free-interaction groups, whatever their special techniques or theoretical bases, seek to create a climate that fosters the development of greater self-reliance, spontaneity, and maturity in the members. They

encourage free expression of feeling and discussion of personal prob-lems, relying primarily on the shared experiences of the participants to help each one to find better solutions for himself. The responsibility for the conduct of the meetings is placed largely on the group members, the therapist trying to facilitate their interactions and to clarify the meanings of their behavior.

How can one choose a group therapist?

Most trained group psychotherapists are psychiatrists, psychologists, or psychiatric social workers. Some clergymen have had training in this approach, as have certain other types of counselors. Many group therapists are members of the American Group Psychotherapy Association, Inc., 1790 Broadway, New York City, or the American Society for Group Psychotherapy and Psychodrama. Information about the location of members can be obtained from these offices.

Is group therapy more economical than individual therapy?

Most therapists charge less for group sessions than for individual appointments, but the choice of therapy should be based on the method that is best for the patient rather than on financial considerations.

What principles guide the selection of patients for group therapy?

Group methods can be used with every type of patient. In general, the sicker the patient or the more deviant his behavior, the more directive the form of group therapy. Free-interaction groups may be especially helpful for patients who are uneasy with others (if this is not extreme), or for those who tend to express their distress by bodily symptoms rather than by words.

In free-interaction groups, since each patient must continually cope with the real or anticipated reactions of others encouraged to express these reactions, patients who are easily hurt by criticism or cannot hold their own in a competitive atmosphere may find such therapy unduly strenuous. These groups may also be difficult for patients who readily "catch" the complaints of others, or who are unduly affected by hearing about others' problems.

How are groups composed?

The group leader strives for "optimal distance" among the members of a group, that is, they should not be so similar that they bore

each other or so different that they can't communicate. For example, in groups of children or adolescents, the age range should not be more than a year or two, because this may make a great difference psychologically, but adults in the same group may differ by as many as twenty years. Psychoneurotics, antisocial personalities, alcoholics, and the overtly insane should be in separate groups. Groups containing both sexes tend to get off to a slower start than groups of only one sex, but often develop better results.

Can husband and wife join the same group? Can friends?

In composing a group, the same principle should apply to all its members. Thus marriage counseling groups composed exclusively of marital pairs can work well, but the inclusion of a married couple in a group otherwise composed of strangers usually causes trouble. Similarly, it is possible to organize groups of persons, all of whom meet in other settings also, such as students at a college, but it is not advisable to mix groups of friends and strangers. Strangers do not have to deal with each other between meetings, which tends to lead to a different type of discussion than if members know that matters brought up in the meeting may disturb their relationships throughout the week.

What is the best size for a therapy group?

In general, the more intensive and interactive the group, the smaller its size. For the most interaction, the group should probably have not less than five members and no more than eight members. In larger groups the pattern becomes more one of speaker and audience, as for example in Alcoholics Anonymous. Groups of this general type may have twenty-five or more members at a meeting.

How well attended are group sessions?

There tends to be a heavy turnover in early meetings, which members find quite strenuous. One study of many different free-interaction groups found that on the average about one-third of the members dropped out before the fourth session. After the groups had stabilized, the average attendance rate was about 85 per cent, and all members were present for about half the meetings.

How frequently do groups meet and how long are the sessions?

Most groups meet once a week for an hour and a half. Some meet more often, but none less frequently.

How long is a course of group therapy?

It is impossible to generalize about this. Some members benefit in a few meetings, and some can profit from attendance for years. In general, the specific benefits of group therapy depend on a sense of group cohesiveness, and this usually takes several months to reach full strength.

Can individual and group therapy be combined?

Yes, and this combined treatment is often chosen. Group and individual sessions can facilitate and complement each other. Often, for example, subjects which the patient finds humiliating can be more easily brought up first in individual sessions, whereas attitudes such as anger toward the therapist are more easily mentioned first in the group. The group is society in miniature; the individual interview is a place where the patient can examine his problems in a leisurely fashion, assured of the therapist's undivided attention and of freedom from interruption by others. Both settings have their values. The patient may react quite differently to the same material in the group and in the therapist's office, with useful results.

Do group members tend to get together informally in the absence of the therapist?

This happens almost always. Some therapists believe it impedes therapy; others encourage it and even make it a regular part of the treatment program. On the one hand, informal meetings break down the "social incognito" that may make it easier for members to speak freely in the group. On the other hand, informal sessions tend to strengthen group solidarity and to enable the members to discuss more freely certain matters, such as their attitudes toward the therapist, than they could in the therapist's presence. During the regular sessions, members are always encouraged to discuss these informal meetings.

What are some important sources of tension in group meetings?

Initially tensions arise because members are strangers to each other, or because they reveal painful personal problems before the group is ready to support them. As they become better acquainted, members may annoy each other because they represent different points of view or life experiences or because in others, they detect traits which they dislike in themselves—so-called mirror reactions—or because they

react to each other as if they were emotionally disturbing family members—so-called transference reactions. One of the values of group therapy is that, in contrast to everyday life where antagonism ruptures relationships, patients who are upset by each other must keep in communication until the source of the friction is discovered. Often it can then be resolved, but even if it cannot, both members usually will have gained self-confidence and deeper self-knowledge through their struggle.

How do therapy groups give their members emotional support?

Members gain heightened morale from learning that they are taken seriously by their peers. Their feelings of isolation are reduced by the discovery of common problems or kinds of distress, and by the feeling of group belongingness that develops from the sharing of experiences. Members are encouraged by each other's improvement, and especially by discovering that they can help each other. Most psychiatric patients have been made to feel that they are a burden or annoyance to others, and the individual therapeutic interview in which all help flows from the therapist offers no opportunity to dispel this feeling through actions. In the group, members can give as well as receive help.

What is the present status of group methods of therapy? Future prospects?

Group procedures have added a new dimension to psychotherapy, and their great flexibility makes them applicable to a very wide range of illnesses and behavior difficulties. Special training in these methods is now offered in most psychiatric residency training programs as well as in annual institutes sponsored by group therapy associations. Thus it seems likely that the use of these methods will probably continue to increase for some time. If the history of other forms of treatment is a reliable guide, group therapies are probably just beginning to emerge from the initial period of overenthusiasm. Eventually they will become a routine part of the psychotherapist's procedure. At present there are no reliable data for comparing the effectiveness of different forms of psychotherapy, but, in general, group therapies seem to be at least as successful as individual methods.

GUILT

by ERICH LINDEMANN, M.D.
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What do we mean by guilt?

A person is considered as guilty if he has broken a law or does not live up to the justified expectations of others. In this sense guilt often is used as a legal term. In the mental health field, one is particularly concerned about guilt feelings and their appropriateness to a person's life situation. One may feel guilty when one has not done anything essentially wrong, and one may fail to show guilt feelings over actions which everyone else would consider wrongdoing.

How do guilt feelings come about under normal conditions?

In the mentally healthy person they come as an automatic consequence to wrong action both with respect to commission and omission of what should have been done. They lead to remorse and restitution and are an important part in regulating healthy conduct.

What are abnormal feelings of guilt? Do they occur in different kinds of conditions?

Abnormal guilt feelings are often found in mood depressions in which persons torment themselves over minor failings with great severity. Persons with obsessive-compulsive neuroses also often feel the need to scrutinize their conduct and have a confession compulsion, reporting to psychiatrists or clergymen many minor failings, asking for reassurance.

Is anything known about shared guilt feelings between different individuals?

Since many acts of violence and delinquency are carried out by groups, guilt in the legal sense is often shared by several persons who were accomplices. Psychological guilt feelings more often are felt by a group of persons who by alertness and timely action might have prevented a tragedy.

Are there differences between men and women so far as guilt feelings are concerned?

Obsessive neuroses are slightly more common in men; depressive reactions are particularly frequent in women during the involutional period. Extreme guilt feelings over minor deeds many years ago with a great need for self-punishment preoccupy such persons.

Do children feel guilty?

From infancy, no. The small child may fear punishment for his mischief and may be deterred in this way. He may also feel embarrassed and ashamed before other children and the parents when discovered, but it is only during the first or second year of elementary school that there develops a real sense of guilt in the sense that the norms and codes of good behavior become an internal part of the child's life, so that he may accuse himself, punish himself, or make restitution, even if not discovered.

Can abnormal guilt feelings become so severe that they lead to death?

A good many forms of suicide or suicidal tendencies are the consequence of profound guilt feelings over deeds for which only death seems to be the appropriate restitution.

What are the relationships of guilt feelings to grief and bereavement?

Many bereaved persons are painfully aware of the many kind and helpful actions with respect to the deceased person which might have improved the relationship or even prevented the death. (See *Grief*)

If guilt feelings are too severe, can they be "put out of one's mind"?

Yes. A great many people after having committed acts which, according to their code, are very reprehensible will have no sense of guilt but will find themselves preoccupied with danger to their physical health, with social failure, and with an inclination to spoil the chances they have for happiness and rewards. Some forms of accident proneness are a consequence of this same condition: of unconscious guilt feelings that demand punishment and forbid the enjoyment of life.

What about insufficient feelings of guilt?

A considerable number of delinquent persons who repeatedly get into difficulties with the law are found to be defective in the develop-

ment of a normal conscience. They have not internalized the values and rules of good conduct that their parents presented to them or, indeed, have not had any good models for approved behavior. They often need wise, accepting counseling before they can, later in life, develop the kind of conscience that will protect them from further delinquency.

How can one help a person who is preoccupied with excessive feelings of guilt?

It usually does not help to argue with the person about the details of his self-accusation. He will find other reasons for feeling guilty, since often the self-accusations are the expression of great feelings of hostility which were previously meant for somebody else but are now expressed against himself. Psychotherapy will have to come to terms with this high level of hostility and help the individual to discharge it in small amounts where it is not dangerous. A great many persons who feel guilty find that hard work or social service to the sick and needy are helpful measures in dealing with their need to make restitution.

Do some depressions become better without therapy?

Yes, many such conditions do. The need for punishment and restitution gradually becomes lessened and gives way to a more normal level of guilt feelings. (See *Depressions*)

Does religious counseling help such persons?

Most forms of religious beliefs include detailed considerations of guilt, sin, and human failing. They have historically developed ceremonials and "church" procedures to deal with remorse and restitution. Often it is very helpful to have both the clergyman and the psychiatrist consider the plight of an individual who is suffering from depression or from obsessive preoccupations with guilt feelings so that the resources of both professions can be made effective in distinguishing psychological complications and conflicts and religious factors. (See *Religion and Psychiatry; Pastoral Counseling*)

HEADACHES

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What is a headache?

The dictionary defines a headache simply as "a pain in the head." A medical term for headache, *cephalalgia,* comes from three Greek words meaning "a condition of head pain." Headache and head pains are a symptom, not a disease. As an isolated symptom, it is not in itself diagnostic of any disorder. Headache may be indicative of a disturbance within the cranium, in other systems of the body, in the personality, in the environment, or a combination of these factors.

Why is a headache important?

It has been estimated that headache is the chief complaint in more than half the patients who seek the attention of physicians. As a symptom, headache may be a mask under which a disease travels incognito or it may be a warning, arising in the course of a disease, that points to new dangers and complications. Thus a person may mask a symptom by the use of aspirin or other remedies while the underlying disease lies unrecognized or progresses past the point of control. Furthermore, headache interferes with normal, effective, and happy living, as well as causing a loss of manpower hours in industry and the community.

How do headaches occur?

Only in the past twenty-five years have the mechanisms of headache been systematically explored. Most of the information has come from experiments using various pharmacologic agents, mechanical devices, clues offered by the neurosurgeon in the operating room, and observant patients. The structures of the head that are sensitive to pain and a potential source of headache include the tissues of the scalp, blood vessels, and certain of the brain coverings. The brain tissue does not feel pain on direct stimulation, nor do the bones of the skull.

Pain in the tissues inside and on the surface of the head can be caused in a number of ways:

1) Distention or dilation of arteries of the head. Headaches of migraine, fever, toxic states, hangover, and hunger are some that relate to pain in the cranial arteries.

2) Traction pulling on pain sensitive structures within the head. Brain tumors, abscesses, or other expanding intracranial lesions do not usually cause pain through direct pressure on brain tissue, but rather by the way they pull on the arteries or other pain sensitive structures within the cranium.

3) Inflammation or irritation of pain sensitive structures, for example, inflamed brain covering as seen in meningitis or an inflammation of an artery.

4) Prolonged excessive contraction of the muscles of the neck and scalp. One of the commonest of headaches, the muscle contraction "tension" headache, is usually due to adverse reactions (to life stresses) that are mainly emotional. An element of postural strain sometimes contributes to the development of the muscle contraction headache in such occupations as typing or drafting, in which the head may be held forward much of the time. Trauma to the neck muscles and ligaments, or irritation of the nerves in that area, or advanced osteoarthritis may also produce excessive muscle contraction and headaches associated with contraction of neck muscles.

5) Spreading pain. Such pain may spread into a general headache from a localized disturbance in the eye, ear, nose, sinuses, or infected teeth.

6) Psychogenic. Headaches which are probably part of the illness of an emotional disorder and in which pain mechanisms in the periphery or on the surface are nonexistent.

How do doctors classify headache?

Headache may be classified as acute or chronic. The acute headache occurs suddenly and occasionally and is usually an associated part of an illness. Chronic headaches recur more or less frequently. Fortunately about 90 per cent of all chronic headaches in office practice are more or less benign, involving psychophysical factors rather than permanent structural changes in the body or any serious illness. They can be classified as vascular headaches of the migraine type and the muscle contraction "tension" headache.

What is migraine?

Migraine literally means half-sided headaches. The "classic" migraine is ushered in usually by a sudden onset of visual symptoms consisting of colored zigzag lights or partial loss of vision. Occasionally numbness of the face, tongue, and hand may precede the headache; usually within a period of twenty to thirty minutes this is followed by pain on one side of the head, which is a throbbing sensation accompanied by nausea and vomiting lasting for several or more hours—and it frequently spreads to other parts of the head in the late stages.

For every classic attack, however, approximately ten attacks of "ordinary" migraine or sick headache are to be found in migrainous individuals. These attacks do not give the usual warning, the pain may be on one side or both sides of the head, may throb or be a steady ache, and last from a few hours to several days. Often the attack is accompanied by widespread disorganization of bodily functions, including nausea, vomiting, fatigue, chills, and localized or general swelling. About two out of three patients with migraine have a family history of the disorder.

A third type of migraine, called the "cluster" migraine, involves a series of closely spaced attacks followed by remissions of months or even years. The pain is usually on one side, localized in the region of the eye and temple; it commences suddenly, often waking the patient at night and is usually accompanied by congestion and profuse watering of the eye, running and/or stuffiness of the nose. After twenty minutes to several hours the pain usually stops as suddenly as it begins.

All types of migraine headaches involve the vascular system of the head. For some reason not fully understood, tensions, stresses, and emotional conflicts affect the blood vessels of migraine patients.

Are all people who have migraine compulsive, perfectionistic, and methodical?

No. Not all patients with migraine have this personality profile. In fact far more people with these character traits do not have headaches than those without such traits.

What is muscle contraction or tension headache?

This type of headache is probably the most common of all types of chronic recurring headache. The patient complains of periodic headaches of varying frequency and severity, which often persist for several hours or many days. The pain is usually on both sides of the

head or neck, although it may be felt around the entire head, like a hatband. Examination at the time of headache will reveal excessive contraction of the muscles of the neck and/or scalp. Prolonged muscle contraction is presumed to be the cause of pain; it has also been suggested that lack of blood supply to the involved muscles may be an added factor in producing the pain.

What are some misconceptions about headache?

The severity of headache is not indicative of the seriousness of the underlying disorder. A mild headache could indicate a more serious underlying disturbance than might a severe headache, although this is not always so.

Chronic sinus trouble is an uncommon cause of headache; but acute sinus trouble often is accompanied by headache.

Constipation rarely, if ever, causes headache.

The need for reading or distant vision glasses rarely causes headache.

Headaches may be associated with high blood pressure, but the severity or frequency of such headache is no indicator of the height of the blood pressure. The headache frequently occurs early in the morning when the blood pressure is at its lowest. On the other hand, low blood pressure is rarely a cause of headache. The majority of patients who suffer head discomfort and blame it on low blood pressure are attributing the headache to a cause that does not exist.

Which headaches are storm signals for prompt and thorough medical checkups?

Headaches that should alert us to possible serious disorder are:

Sudden, severe headache "out of the blue."
Headache associated with fever.
Headache associated with convulsions.
Headache accompanied by confusion or lessening of consciousness.
Headache following a blow on the head.
Headache associated with local pain in the eye, ear, or elsewhere.
Headache beginning in the older person previously free of headache.
Recurring headache in children.
Headache (at any age) that interferes with normal living.
Daily or frequent headache.

What is the role of allergy in headache?

Studies by many competent investigators indicate that allergy is an uncommon cause of chronic recurring headaches. The principal allergic factors in headache are foods and inhalants. Engorgement of the nasal mucosa (rhinitis) is frequently associated with the allergic headache. Rhinitis in adults is usually due to inhaled allergens or infection, rarely to foods.

Patients subject to migraine as part of a generalized reaction may experience an attack precipitated by the administration of a particular food to which they are sensitive. However, this is not a common cause of migraine.

How do psychogenic factors cause headache?

In patients with psychic distress, headaches occur because of two mechanisms.

In one group the mental conflict stimulates the nervous system, producing changes in the caliber of the blood vessels of the head, or causing excessive contraction of the muscles of the neck and scalp. In another group the mechanism of headache is on the basis of a conversion reaction (transformation of repressed ideas or impulses plus the psychologic defenses against them into a physical manifestation). To the patient the symptom represents a specific unconscious symbolic meaning which is not consciously recognized. In this patient the head is used as the organ of expression of the conflict. (See *Mental Mechanisms*)

What are some of the factors in everyday living that could lead to chronic recurring headaches?

Some of these factors are:
1) Overcrowded schedules.
2) Poor, irregular meals.
3) Overanxiety regarding personal and social obligations such as preparations for guests, shopping, and other trips.
4) Lack of exercise, recreation, avocation, and vacation.
5) Aiming for perfectionism and impossible goals.
6) Suffering in silence because of an inability to express aggressive feelings toward a parent or another respected and loved person.

HEREDITY AND MENTAL HEALTH

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What do we need to know about the history of heredity and mental health to help us understand the current status of knowledge in these fields?

It should be remembered that the science of heredity (genetics) and the currently used classifications of mental disorder are of only recent origin. Both are primarily products of the twentieth century. Knowledge about genes—the carriers of heredity—is now growing at a more rapid rate than ever, and new systems of classifying mental disorders continue to be proposed regularly. Our knowledge about the relationship between the two fields is influenced by the state of knowledge about either at any given time. Therefore it is safe to say that what we now know about these matters is fairly primitive, and that the technical, detailed answers to questions about the link between heredity and mental health belong to the future.

Is mental illness inherited?

This question seemed to make sense in the early days of psychiatry. At that time the basic mechanisms of heredity were only just beginning to be understood and the relationships between the various mental disorders were poorly visualized and ill defined. All forms of mental illness were more or less lumped together, and many workers in the field talked in terms of a "hereditary taint." If a number of people related by blood had epilepsy or "feeblemindedness," drank excessively or committed crimes, were short or tall, geniuses or insane, stuttered or limped, were left-handed, hunchbacked, or precocious, had headaches or a "fondness for certain words," such people were thought to be showing signs of a common heredity.

In time, of course, these notions came to be recognized as scientifically absurd. One reaction to the extreme overgeneralizations about

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mental illness was to consider the possibility that certain specific mental symptoms might be inherited, but in the main, investigators have studied separately the possible inheritance of certain clusters of symptoms called mental disorders, often assumed to be biologically unitary diseases. The inheritance of such disorders is discussed in this article.

How can scientists tell if certain mental disorders are inherited?

There are two main ways by which the inheritance of mental disorders is studied. Each has its own problems.

1) The investigator determines how often the particular disorder occurs in the general population. He then finds a great number of people who have the disorder and examines all the close blood relatives of these people. If the disorder occurs more frequently among their relatives than among the general population, the finding is taken as evidence that the disorder is inherited. The investigator notes the frequency with which the illness occurs among parents, children, brothers, sisters, aunts, uncles, nephews, and nieces, since these frequencies could provide important information about the nature of the gene that may be responsible for the disorder. He may also study specific lineages of patients, with the same purpose in mind. But he also must pay attention to any environmental factors that may be influencing his findings.

2) The investigator studies twins. There are two kinds of twins: identical and fraternal. Identical twins look very much alike and have exactly the same heredity, or genes. Fraternal twins, on the average, have only half their genes in common and are like ordinary brothers and sisters. Identical and fraternal twin pairs are compared with respect to the number of pairs in which both twins or only one twin have the disorder. If the proportion with both twins having the disorder is appreciably higher among the identical twin pairs, it is usually considered to be evidence that the disorder is inherited, but again the investigator must look for possible environmental influences.

If mental illness occurs more often in some families, could it be that these families are living under conditions or behaving toward one another in ways that cause mental illness among them?

This possibility exists. For example, several mental disorders occur more often in families from lower social and economic classes. The reasons for this are not entirely clear. Also many psychiatrists and psychologists in the United States believe that most mental disorders occur because of peculiar relationships among members of certain families,

and some have tried to describe the nature of these relationships. (See *Social Factors in Mental Illness; Mental Disorders in the United States*)

If a pair of identical twins has a given mental disorder more often than a pair of fraternal twins, could it be that there is something special about being identical twins that makes for mental illness?

This possibility also exists. However, the best evidence available indicates that the major mental disorders do not occur more frequently among twins than among persons born singly. This fact reduces the importance of special twinship factors as causes of these mental disorders, and leads to the inference that studies of twins have provided most of our firm knowledge about heredity and mental health. However, it is possible that some psychological factors exist that are unique to identical twins, in that if one twin develops a disorder of behavior, the second is especially prone to develop that same disorder, but such factors have not yet been demonstrated.

If pairs of identical twins exist in which one twin has a mental disorder and the other does not, doesn't that prove that the disorder is not inherited since both twins have exactly the same heredity?

No, because not everyone who inherits the genes responsible for a given disease shows the symptoms of that disease. However, the fact that such twin pairs do occur indicates that factors other than heredity may play an important role with respect to whether the recognized disorder does or does not arise.

Which mental disorders have been studied with respect to whether or not they are inherited?

Schizophrenia, the most widespread of the severe disorders, has been the most extensively studied by far. Others include manic-depressive psychosis, mental disorders associated with advancing age, alcoholism, various forms of mental deficiency, some psychosomatic illnesses, neurosis, homosexuality, criminality, suicide, bed-wetting, epilepsy, and several neurological disorders that impair mental functioning in various degrees.

Are these disorders really separate and distinct disease entities?

Those mental illnesses for which a specific lesion in the brain or a biochemical abnormality can be demonstrated can usually be clearly defined as distinct diseases. However, for most forms of behavior we

call mentally ill, no physical lesions or abnormalities have been found. Such illnesses are defined solely in terms of patients' behavior, and are, therefore, better called behavioral disorders, at least for the time being. Almost any kind of human behavior is decidedly complex, and it is not surprising that the behavior of many patients shades off into the border-lands between the classically described disorders. Such patients may be classified by some experts as having one disorder and, by others, as having a different disorder. Sometimes the behavior of a patient changes, so that he may be said to have one disorder when first admitted, but another disorder when examined a few years later.

Sometimes a patient may show a wide complex of behavioral disorders, in that he may have a long history of excessive drinking, homosexual behavior, and a criminal record, but at the same time he may also show symptoms that are characteristic of schizophrenia. From the point of view of heredity, shall it be said that he has inherited four separate genes, one each for alcoholism, homosexuality, criminality, and schizophrenia, or one gene that expresses itself in at least four ways? Within a given disorder, such as schizophrenia or as neurosis, a wide range of behaviors is included. These are grouped as "subtypes" rather than as different disorders, which some may possibly be. Thus it can be seen that the task of identifying separate behavioral disorders that correspond to separate inherited factors is replete with difficulties at the very outset because of the problem of identifying unique disease entities among the behavioral disorders. However, some progress has been made in this regard.

Is schizophrenia a single, inherited disease?

The mass of evidence accumulated from both family and twin studies is impressively consistent with the belief that inheritance plays an important role in schizophrenia. However, there is some evidence to show that at least one form of schizophrenia occurs without any hereditary basis. (See *Schizophrenia*)

Are people who have schizophrenia likely to have had parents who were also known to be schizophrenic?

No. In the great majority of cases, neither parent will have ever been admitted to a mental hospital or diagnosed as schizophrenic. However, intensive examination of such parents has tentatively suggested that among most pairs, at least one shows a mild form of schizophrenia that does not require hospitalization, or shows some unusual or pecu-

liar kind of behavior, either with regard to how he or she treats other members of the family or thinks about certain problems. These matters, however, are only just beginning to be studied and the findings are far from conclusive.

If a person with schizophrenia marries a normal person, are their children likely to be schizophrenic?

They are more likely than a normal couple to have a child who becomes schizophrenic; the chances are that about one or two of every ten children born to such couples will be hospitalized for schizophrenia.

Is a woman with schizophrenia likely to have more or less schizophrenic children than a man with schizophrenia?

Schizophrenic women are more likely to marry than schizophrenic men, and are likely to have more children if they do marry. Thus more people with schizophrenia have schizophrenic mothers than fathers, but the proportion of schizophrenic and normal children seems to be about the same for schizophrenic mothers and fathers.

If a schizophrenic man marries a schizophrenic woman, are their children likely to be schizophrenic?

At the present time the best estimate is that about half their children would become hospitalized schizophrenics and half would not.

Is schizophrenia in young children due to the same kind of inherited factors as schizophrenia occurring in adults?

The best evidence available suggests that it is.

What is inherited that makes people become schizophrenic?

Nobody knows. Some scientists believe that it is a defect of personality or a specific error of biochemistry that is inherited, and much research today is dedicated to finding out what that error may be. (See *Biological Factors in Mental Illness*)

Are environmental factors important in causing schizophrenia?

Yes. We know this because in approximately one-third of identical twin pairs in which one twin is known to have schizophrenia, the other twin does not. Since both twins have the same heredity, environmental factors must be helping to cause the disorder either to be expressed in one twin or to be suppressed in the other. Also there is evidence to

show that schizophrenia occurs in some cases without any apparent hereditary involvement. A third source of evidence derives from differences between male and female twins, and between male and female relatives with respect to the percentage of pairs who develop the disorder. Fourthly, a pair of identical twins may often show marked differences in the age at which the disorder becomes manifest, the severity of the symptoms, and the final outcome of the course of illness, indicating that environmental factors do influence the disorder in fundamental respects.

Which environmental factors are important in causing schizophrenia?

Nobody really knows, but many things have been suggested, including some prenatal factors, birth trauma, head injuries, infections, weight changes, body build, worry, stress, alcohol, confusion about one's personal identity, conditions of social and economic deprivation, broken homes, maternal upset during the patient's early infancy, certain kinds of mothers and fathers, being subjected to patterns of irrational thinking, homosexual inclinations, responding with too much anxiety in certain situations, failure to gratify certain needs in early childhood, and many others.

Does this mean that both hereditary and environmental factors cause schizophrenia?

Yes. Of course this indicates only that we are now taking our first steps toward solving the basic problem. Our future task is to identify these hereditary and environmental factors and to determine how they combine to produce different forms of schizophrenia.

Are other severe mental disorders also inherited?

Evidence suggests that the disorders called manic-depressive psychosis and involutional melancholia involve inherited factors. The latter is thought by one leading investigator to be related hereditarily to schizophrenia. Some scientists think that manic-depressive psychosis is also related in some complex hereditary way to schizophrenia, but some believe that it is caused by an unrelated, specific inherited factor. In these matters, differences between investigators probably occur because of difficulties regarding the classification of cases. Some mental disorders of old age also seem to depend upon heredity. But in these severe disorders, as in schizophrenia, environment, too, makes its contribution. (See *Manic-Depressive Psychosis*)

Is mental deficiency inherited?

A proper understanding of this problem requires that we distinguish between two forms of inherited mental deficiency. The first involves a fairly large group of people who are not very bright, but who manage well enough in the world performing tasks where only simple judgments and decisions are involved. These people may be said to have a low I.Q. Intelligence is inherited in substantial part, although environmental factors can affect it considerably, but there is no single gene for intelligence as such. Rather a number of inherited factors combine to make for greater or less intellectual capacity, and this first group of people has been unfortunate with respect to the distribution of the normally inherited factors they have received.

The second group involves more severely affected individuals who have inherited a specific abnormal gene that directly or indirectly affects the functioning of the brain, leading to marked intellectual impairment. This group is smaller than the first, but poses graver personal and custodial problems because of the inability of these people to take care of themselves. In three of these disorders, the errors of biochemistry that are inherited have become so sufficiently well understood that early detection and treatment have become possible. It is interesting to note that until the nature of the biochemical error was discovered, these cases were grouped with, and not distinguishable from, some other cases of mental defect. Many cases of mental deficiency are caused by brain disease or injury. (See *Nutrition and Mental Health; Mental Retardation*)

Is it true that mentally ill and mentally defective persons have more children than other people do, and are gradually contaminating the human race?

This is an old wives' tale that used to be widely believed and still is accepted by many people today. Actually, the reverse is true. Mentally ill or defective persons often have a diminished sex drive, or various disturbances of the sex drive that reduce their interest in sex or their ability to procreate. Often, they are not attractive to or attracted to the opposite sex and do not find partners readily. Marriage is frequently out of the question since they either cannot support themselves or a family, or cannot manage a home. Moreover if they do marry, they are likely to have fewer children than the average normal couple. It is true, however, that people with the highest I.Q.'s tend to have fewer children than the general population, but the only evi-

dence available does not indicate that a general decline of intelligence has occurred as a consequence in the population at large. (See *Intelligence*)

Is it true that if close relatives marry, they are likely to have mentally ill or mentally defective children?

This ancient belief was based on sound observations that find considerable support in modern genetic studies. It is clear that children of cousin marriages are much more likely to show latent genetic traits in the family, both good and bad, than children of unrelated parents. Therefore there will be a higher probability of very high intelligence, but also of mental retardation or defect. There is some tentative evidence to suggest that a similar but less pronounced increase occurs for schizophrenia.

Is epilepsy inherited?

In a substantial proportion of the convulsive disorders called epilepsy, heredity is the principal cause, although the chances of an epileptic having an epileptic child are low. Different patterns of electrical recordings made from the brain are known to be inherited, and epileptic disorders are associated with certain of these brain wave patterns. However, perhaps a quarter to a third of all cases of epilepsy are caused by brain damage through injury or disease. (See *Epilepsy and Other Paroxysmal Disorders*)

Is homosexuality inherited?

Research on this question is made difficult by the cultural taboos surrounding such behavior, and the reluctance of individuals to talk about it with strangers. In the one systematic twin study done to date, the findings appear to be strikingly in favor of a hereditary basis for male homosexuality. However, it is not likely to be a single, specific factor. Among the thirty-seven pairs of identical male twins studied, both twins were homosexual in every instance. This contrasted strikingly with the findings among fraternal twin pairs. However, among the identical twins, six pairs were schizophrenic, and twenty-two cases were said to be schizoid (a disorder that may be a mild form of schizophrenia), obsessive-compulsive (a form of neurosis), or excessively alcoholic, so that homosexuality may be an expression of various underlying disturbances that may in turn have different hereditary bases.

As yet, no specific relationship has been found between biological

factors that might be inherited, such as sex hormone disturbances or irregularities of primary or secondary sexual characteristics, and homosexuality. Moreover, some investigators have marshaled evidence that indicates that whether one thinks of oneself or behaves sexually as male or female depends primarily on how he or she is reared during the first two and a half years of life. We have virtually no information about the inheritance of homosexuality in women. (See *Homosexuality*)

Is alcoholism inherited?

There is some evidence to indicate that inherited factors contribute to the development of chronic alcoholism, but here, too, environment plays an important role. It is interesting to note that some strains of rats voluntarily consume more alcohol than others, and that the offspring of rats that consume relatively large amounts of available alcohol also tend to be "heavy drinkers." (See *Alcoholism*)

Are neurotic disorders inherited?

As a general rule, when disturbances of behavior are milder, the problem of classifying them reliably is greater. Those nervous disorders called neurotic often fall into this category, so that difficulties surrounding research on their possible inheritance are even greater than in research on those disorders discussed earlier. Relatively few genetic studies have been done on cases requiring clinical examination and care, although a number have been concerned with the inheritance of neurotic traits as measured by tests or written answers to questions about oneself by ordinary people, usually schoolchildren. The findings generally fall into a common pattern and suggest that inherited factors probably play a role in the development of neurotic disorders, that there is no single specific gene for neurosis, that environmental factors are importantly involved, and that striking sex differences occur with respect to various kinds of neurotic disturbance. (See *Neuroses*)

The same general pattern probably applies to some so-called psychosomatic disorders as well, but the inherited factors may involve specific bodily responses to stress, such as high heart rate or pulse pressure, or the production of large amounts of a certain gastric enzyme that predisposes individuals to duodenal ulcers. It is interesting that a specific nervous behavior that is relatively involuntary, such as nocturnal bedwetting, seems to have a hereditary basis, whereas one that involves a relatively voluntary act, such as suicide, does not. (See *Psychosomatic Illness*)

Is criminality inherited?

The general formulations made about heredity and the nervous disorders apply to criminality as well. It once was believed that criminality was inherited, and that there were criminal "types." One author dramatized this viewpoint by referring to "crime as destiny." It may be that certain personality characteristics, such as impulsiveness, aggressiveness, or exaggerated responses to frustration are determined in part by heredity, and it is true that such traits abet transgression. It is also true that traits that are more clearly a function of heredity, such as certain irregularities of brain wave patterns or low intelligence, may make for poor self-control or poor judgment, increasing the possibility of one's committing crimes. However, the significant role of a poor socioeconomic and familial environment in criminality is well established. (See *Crime and Mental Disorders*)

Is personality or temperament inherited?

Although there is a long history of research on this problem, the results are most often inconclusive or contradictory. Traits studied include introversion, perseveration, tempo preferences, handwriting characteristics, speed of response, decisiveness, persistence, dominance, self-sufficiency, self-confidence, sociability, patterns of interpreting ambiguous figures, and others. Some evidence suggests a hereditary basis for introversion-extroversion, but more thorough studies are needed. In contrast, many traits of temperament have been shown to be inherited in animals, including activity, emotionality, aggressiveness, fearfulness, and social behavior. Clearly, however, we cannot generalize from animals to man about such matters. (See *Personality*)

Does exposure to radiation increase the possibility that mental illness will be increasingly transmitted from generation to generation?

Unfortunately, the sex cells that carry the genes are the parts of the body most readily affected by radiation. These effects involve changes in the genes, which are almost invariably bad; beneficial changes in man are unknown. Once a gene changes, it is transmitted to future generations in its changed state. Such changes could theoretically affect mental health directly, through changes in the nervous or hormonal systems, or indirectly, through the dire psychological impact on families bearing and breeding children with an inherited physical deformity. At the low levels of naturally occurring radiation, such

hazards are not noteworthy, but the danger increases in proportion to the amount of exposure to radiation over time.

Is it legal to sterilize people because they are mentally ill or mentally defective?

The laws vary from state to state. Since the beginning of this century, approximately thirty states have passed laws permitting the sterilization of mentally ill or defective persons, and to date over sixty thousand such sterilizations have been officially reported. In some states the law is "compulsory," but it is obvious that in none of these states has this aspect of the law been taken seriously, for various reasons. California has performed the most sterilizations by far, having accounted for approximately one-third of all sterilizations in the United States. In recent years, however, sterilization in California has been halted almost altogether, and the states reporting most sterilizations are North Carolina, Georgia, and Virginia. There has been no uniformity regarding the application of such laws. For example, Connecticut has sterilized more than ten times as many women as men, whereas Kansas and Delaware have actually sterilized more men than women. Michigan and Minnesota have sterilized four to seven times as many mentally deficient as mentally ill persons, whereas in California and Georgia the large majority of cases were mentally ill. The constitutionality of eugenic sterilization is not yet finally settled. (See *Eugenic Sterilization*)

How can people get advice about the possibility that they might have children who will be mentally ill or defective?

A number of so-called heredity clinics or counseling centers now exist in various university or hospital centers around the country. Usually, they provide free consultation. Our knowledge, however, regarding the inheritance of behavioral disorders is fragmentary and probably contains many errors. Since the counseling provided at these centers is based solely on this knowledge, both the counselor and the counselee should be aware that the best risk figures that can be provided about the behavioral disorders have a wide margin of error. On the other hand, risk figures regarding some types of mental deficiency may be provided with much greater confidence. People seeking such counsel should be prepared to describe the history of mental disturbance in family members and relatives as accurately as possible.

Are undesirable traits or behavioral disorders that are inherited more difficult to treat than acquired ones?

No. The efficacy of treatment depends in the final analysis on the specificity of knowledge regarding what is inherited and what is acquired. As such knowledge grows, we are usually able to devise a form of treatment that is specific to the particular disorder.

What are the prospects for achieving a detailed understanding of the relationship between heredity and mental health?

The prospects are good, since there is a great deal of scientific interest in this problem and since methods of study are becoming increasingly sophisticated. However, much of the research must be done on a large scale, as far as we now can tell. It will be both expensive and time-consuming, and will require the active cooperation of many unfortunate families with afflicted members. Though the accumulation of such knowledge must be distressingly slow, its potential rewards to all mankind are sufficiently great to keep the quest from flagging.